Providing a Quality Life While Avoiding Restraints

GUIDELINE FOR EDUCATION

January 2000

Jointly developed by providers and provider associations in collaboration with
The Bureau of Quality Assurance,
The Wisconsin Board on Aging and Long Term Care, and
The Wisconsin Association of Medical Directors

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GUIDELINE REPRINT PERMISSION GRANTED

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BOALTC (The Ombudsman Program)	Carol Kriemelmeyer & Claudia Stine
Extendicare Health Services, Inc.	Jackie Stone, Director of Care Management
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Meadow View Manor, Sheboygan	Angela Willms, Administrator
Pine Valley Healthcare, Richland Center	Angie Alexander & Dr. Robert Smith

It has been very rewarding to serve with this group of dedicated professionals. BQA remains committed to continuing educational efforts to provide for a quality life for residents while avoiding restraints and preventing deaths and injuries. Please call the Provider Regulation and Quality Improvement section of the Bureau of Quality Assurance at (608) 266-3024 if you have questions or would like additional training in the use of this guideline. Your request will be forwarded to a clinical consultant.

June Doyle, Nursing Consultant
Provider Regulation & Quality Improvement Section
Bureau of Quality Assurance

INTRODUCTION

Health care professionals once were taught that restraints would ensure patient and resident safety. Families, patients and residents learned to accept restraints, particularly side rails, as a method of keeping people safe in hospitals and nursing homes, and restraint use became a standard of practice. However, current research confirms that restraints do not ensure safety and that most residents are safer without restraints. It can be difficult to perceive that care designed to keep patients and residents safe can actually contribute to death or a serious injury.

Nation-wide statistics reveal approximately 200 deaths a year in nursing homes are due to restraints. Generally, one to three deaths occur annually in Wisconsin nursing homes because of restraints.[1] However, in the summer of 1999, the statistics on deaths increased to one resident death per month for June, July and August in Wisconsin nursing homes. All three deaths involved bed side rails. These deaths were strikingly similar to the deaths chronicled in the articles by Dr. Steven Miles listed in the "Side Rails" section of the recommended reading list in Appendix C. Deaths from restraints or side rails are seen as undignified, unnatural and largely preventable, because they are the outcome of a caregiver's intervention.

Simultaneous, collaborative efforts are being made in Wisconsin both to count and report the number of restrained residents accurately and to reduce restraint use through education. The 1998 Annual Survey of Nursing Homes identified the state average percent of restrained residents in January 1999 as 13 percent, down 3 percent from the average of 16 percent in April 1998.[2] The Center for Health Statistics Annual Survey of Nursing Homes Report will continue to collect annual information on the number of restrained residents.

Current aggregate data show progress in restraint reduction; however, there is still room for quality improvement, especially in the area of side rail death prevention. The results of a nation-wide study conducted by Dr. Richard Neufeld indicate that a restrained resident rate of four to five percent is achievable and that a rate of zero percent is often possible.[3]

Restraint use can be a sensitive and intensely personal issue for residents, families and staff. Therefore, decisions about restraints require an individualized approach for each resident. For this reason, **successful education in using alternatives is best accomplished when it is done directly with the people involved.** Ombudsman staff from the Board on Aging and Long Term Care are very helpful for families who worry about the safety of residents. Facilities that have had success in reducing restraints report that continued administrative diligence is a key factor in sustaining continued freedom from restraints and in ensuring resident safety.

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[1] Wisconsin data is from the Department of Health and Family Services Reportable Death Reviews and represents an average over the past four years.

[2] Reported in BQA Memo # 99-051 dated September 3, 1999, and available on the DHFS Web site http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

[2] Nation-wide data is based upon a telephone interview with Dr. Richard R. Neufeld, M.D. of the Jewish Home and Hospital for the Aged, Mount Sinai School of Medicine, New York. The study involved 16 nursing homes across the nation and results are to be published in one of the professional journals in 1999 or 2000.

INSTRUCTIONS

This guideline is a resource for ongoing educational needs. You may photocopy it for training others. It is not regulation and is not required; however, it is consistent with state and federal regulations when properly implemented. Suggested tools and forms may be modified and individualized to suit your particular audience's educational needs. If any material in the guideline is modified, please remove the reference to the Department, Division and Bureau and be sure to maintain the accuracy of the content.

Providers are advised to always use the critical thinking process when developing and implementing training. **Be sure that you carefully assess your learners and tailor the training to their needs and perceptions.** Be aware of any new research, regulatory information or statistical data that becomes available after the publication of this guideline. Evaluate the credibility of the information and incorporate those concepts into your resident care practices and your educational efforts when they are appropriate.

The guideline is designed for use by all disciplines. Interdisciplinary training enhances your results and enriches your training experience. Basic learning outcomes are provided for each of the various types of learners (residents and families, physicians, hospital staff and nursing home staff). Trainers will need to tailor or expand learning outcomes and objectives for areas of concern in various situations.

Educating Residents and Families

Providing A Quality Life While Avoiding Restraints

EDUCATING RESIDENTS and FAMILIES:

PROVIDING A QUALITY LIFE WHILE AVOIDING RESTRAINTS

This module is for nursing home staff to use for training families and residents.

Learning Outcomes:

All of these outcomes cannot be met in one training session. The goal is to achieve these outcomes gradually as the facility, the resident and the family work together to resolve issues and differences in their perspectives. A caring, well informed, interdisciplinary team is essential for this educational process to be effective, and it is wise to include Ombudsman staff.

Family members will:

1. Develop a clear understanding about the resident's right to be free of restraints and of who is the primary decision maker for the resident. Develop an understanding of competency and independence, incapacitation and guardianship.

2. Understand the guardianship and Power of Attorney for Health Care (POAHC) laws and the legal requirements for decision-making for an incapacitated or incompetent individual.

3. Develop a basic consumer's understanding of the federal and state regulations that apply to the care of their family member, especially those related to the limitations of restraint usage.

4. Understand that family members cannot dictate care that is not medically necessary.

5. Understand the team decision-making process utilized in resident care planning, including the roles of the resident, his/her legal representative, the family and the facility staff.

6. Learn the risks and negative effects of restraints and the benefits of using alternatives for the resident and understand that restraints and side rails are *not* benign safety devices.

7. Learn that successful lawsuits more frequently result from deaths due to the unsafe use of restraining devices or side-rails, than from *not* using restraints or side-rails.

8. Understand their special role in providing care-giving staff with information about their loved one so that staff have a better understanding of the individual, what they were like before beginning to deteriorate, and what helps the person feel safe, comfortable and dignified.

9. Develop a sense of trust in care-giving staff that will enable them to work with the facility staff toward a higher resident quality of life and to feel satisfied that they are doing the right thing "for the resident."

10. Recognize their potential role in helping other family members through support groups, family councils, and attending care-planning conferences.

KEY COMPONENTS OF FAMILY TRAINING:

Decision Making

The participation of residents in making decisions about their lives and their care is critical. This is true even though the resident may have a guardian or a health care agent designated under an activated Power of Attorney for Health Care (POAHC). Residents have legal authority to make as many of their own decisions regarding their lives and their care and this must not be circumvented. Only those individuals who have previously executed a POAHC instrument *and* have had two physicians or a physician and a psychologist determine, in writing, that they are incapacitated are able to have their agent substitute for them in making decisions.

Individuals who have merely *executed or originated* a POAHC document and have not yet been determined to be incapacitated *are their own decision-makers*. Even individuals with guardians or *activated* POAHC agents are to participate in decision-making to the fullest extent possible within their limitations. Family members who have close relationships with residents certainly need to be kept involved as a part of the resident's decision making, if that is what the resident wants. However, the family's wishes do not supersede the resident's care planning decisions made together with the interdisciplinary team.

The Ombudsman staff in your area may be of great assistance for resolving any issues that come up in this regard; they can answer questions you may have on this subject. The Ombudsman staff have resource materials that provide clarification of these issues, and they will work with families to resolve these kinds of issues. There is a handout in Appendix A entitled "Legal decision-Making" to use for education.

Role of the Family

Living in a setting that is not your own home is very stressful for anyone, especially the elderly or disabled. Generally, residents' family and friends are the ones who know them best. These are the key people that can help facility staff learn about the resident as quickly as possible and implement what will work for that person. Families often do not realize this, thinking that people in health and residential care settings just "automatically" know what to do for everyone. It is critical that the facility staff members seek out families and other significant people who know the resident in order to learn the special things about the resident that will add quality to life. This also makes the work of the facility staff easier and more enjoyable, especially if the resident is unable to tell others. (For example, "Was the resident able to walk before getting sick and being admitted to the hospital?")

Listen, Listen, Listen

Residents and families all have their own unique way of viewing dangers and risks that are present for a long term care resident. It is very critical that all staff members listen intently to the resident's and the family's concerns and truly "connect" with their perceptions. Their perceptions are far more critical than any articles or research; they only care about what is happening **right now** with their loved one, and they are likely to have traditional ideas about how to keep the resident safe that includes restraining them. It is critical that all staff members do the following:

- Directly communicate with the resident and the family
- Relate to *their* concerns and reality

- Learn what works for each resident, and
- Provide the alternatives that reassure them and keep the resident safe.

Risks must be addressed, as there are risks present in any environment under any circumstance. If we are alive, there are risks.

Proactive Education

The period prior to or upon admission is thought to be "prime-time" for providing education on the provider's philosophy of providing the resident with a quality life. Much goes on prior to and during the admission process, and providers should ***assume*** that the resident and family were overwhelmed and did ***not*** hear much of what was said and done during that period. Frequent re-evaluation of educational needs after admission will help the provider know what information was retained and what needs to be repeated.

Proactively educating prospective residents and families while the potential residents are still living in the community can be effective in developing an understanding of the long-term care philosophy of a quality of life focus, safety of residents and individualized care. Educating residents in the facility who have not yet reached a point where restraints are being considered, and educating their families, will assist them in becoming proactive regarding care as the resident "ages in place." Some people may not be able to tolerate the pictures of side rail deaths that are in journals; however, for staff and for certain residents and families, such graphics may be effective. The trainer must first *assess* and determine what will motivate the learner versus what might erode the trainer's credibility or detract from the trust the trainer is building with the learner. It is critical that the subject not be taken lightly and that families be presented, as is appropriate for them, with **a clear picture of the risk of death from the use of restraints or side rails and an understanding of how quickly accidents can happen.**

PROVIDE RESIDENTS AND FAMILIES WITH EASY ACCESS TO RESOURCES AND RESOURCE PEOPLE SUCH AS:

- The staff in the facility -- the social workers, the therapists, the activity professionals, the nurses, the DON, the dietitian, the pharmacist, the administrator, any available chaplain/pastor or any other staff members who can serve as resource people.

- The Ombudsman's name and phone number. They may forget receiving this upon admission and may not even know who an Ombudsman is. See Appendix A.

- The booklet **"Avoiding Physical Restraint Use: New Standards in Care,**" a guide for residents, families and friends, by the National Citizens Coalition for Nursing Home Reform (NCCNHR), is available for a nominal fee from:

  National Citizens Coalition for Nursing Home Reform
  1224 M. Street. NW, Suite 301
  Washington, DC 20005
  Phone # - (202) 393-2018
  Fax # - (202) 393-4122

- The Bureau of Quality Assurance has developed a pamphlet for families entitled "Avoiding Physical Restraints - What All Nursing Home Residents and Families Need to Know" (PSL-3113). Copies of this brochure may be obtained by writing to:

  Division of Supportive Living
  Bureau of Quality Assurance
  P.O. Box 2969
  Madison, WI 53701-2969

- See the Recommended Reading lists in Appendix C for more resources.

- "Everyone Wins": While no videotape stands alone as a training session, this video is thought by many to be a very good adjunct to the education of families and groups. Give consideration to blending it into your training. If you do not have your own video, a copy is available in each regional BQA office and from many provider associations.

- "A Family Guide to Restraint-Free Care" - Key concepts:
  - The definition of a restraint
  - Restraints do not remove the risk of falls
  - Benefits of restraint-free care outweigh the risks
  - The resident's rights under OBRA & quality of life
  - What happens when a facility begins to remove restraints
  - Role of the family in sharing information, spending time, being open-minded and celebrating successes
  - The ever-changing needs and abilities of the elderly

TRAINING OUTLINE: RESIDENTS AND FAMILIES

Training Planning:

1. Assess families and residents to determine who is a priority for education.

2. Plan general education sessions at family meetings, even if there does not seem to be a problem. This will help residents and families develop a greater understanding of these issues.

3. Involve the resident council and families in the planning.

4. Call the Ombudsman assigned to your facility and seek advice early on in planning and assessing for training needs for any audiences, but especially for families. The Ombudsman may also be able to assist you with training sessions.

5. Review the learning outcomes in the module and add any additional ones that are needed for either group classes or one-to-one education.

Training Implementation:

1. Review the "Becoming A Trainer" module before proceeding with training.

2. Use the same basic process for both individual and one-to-one training sessions. A basic training outline is included in the appendix, and a comprehensive training outline is provided

for each training audience.

3. A pre-training questionnaire, the short version, is most appropriate for family members. Some may not respond well to this approach. If they are not "paper & pencil" people, you may want to just ask the questions at the beginning of the session to introduce the topics and issues. Your professional judgment always takes precedence when using a guideline or training tool.

4. Ask families and residents what their issues are and focus particularly on those issues.

5. The video for families from the "Everyone wins" series is very helpful in introducing the issues and works well to stimulate discussions. If you are going to use it, use it early in the session.

6. Other videos are available, especially one on Resident's Rights that was especially designed for viewing by nursing home residents and families. Information on how this can be obtained is available from your regional office of the Bureau of Quality Assurance.

7. Focus discussion on each of the learning outcomes in the module:

   - Resident's right to be free of restraints
   - Decision-making, competency, guardianship, power of attorney for health care activation
   - Federal and State regulations, facts versus fiction
   - Team decision-making process that includes the resident
   - Risks and dangers of using restraints
   - Benefits of avoiding restraints
   - How deaths and injuries occur with restraints and siderails
   - How family members can work with the facility to provide information that will contribute to the individualized care of the resident
   - How family members who have successfully dealt with these issues can help others

8. Resources include booklets and a pamphlet that can be distributed and discussed – see Appendix B.

9. Utilize the handouts in Appendix B, especially the ones on the benefits of no restraints and the risks of using restraints. These are in large print to facilitate readable overheads.

10. Questions and answers and informal discussion: Review the handout in Appendix B "Answering Tough Questions" to prepare in advance.

11. Use the post-training questionnaire for those who are amenable to paper and pencil, or verbally ask the questions on the post test and discuss any remaining issues.

12. Evaluation of the training: If at all possible, use a paper format with the families. A sample is provided in the "Becoming a Trainer" section or you can use your own. If not possible with your training audience, ask them for their ideas on usefulness, etc.

13. The training team should review the results of the training, share the results with the facility leadership and other key people, and make any necessary revisions in the training plans.

14. Establish a plan for ongoing training of new families who will come to your facility and consider doing training in your community, especially to elderly groups.

Physician Education

Providing A Quality Life While Avoiding Restraints

PHYSICIAN EDUCATION: PROVIDING A QUALITY LIFE WHILE AVOIDING RESTRAINTS

This Module is designed for nursing home staff to use for physician training. The participation of the physicians listed below greatly enhanced the quality of this guideline. They are very knowledgeable about resident care issues and can be reached at the numbers listed.

Dr. Ashok C. Choithani, MD
Geriatrics Institute
945 N. 12th Street
Milwaukee, WI 53233
(414) 219-7300

Dr. Rodney Erickson, MD
Medical Director Tomah Care Center
Franciscan Skemp Tomah Clinic
325 Butts Ave
(608) 372-4176

Dr. Richard Kane, MD
Geriatrics Institute
945 N. 12th Street
Milwaukee, WI 53223
(414) 219-7300

Dr. Robert Smith, MD
President, WAMD
Richland Medical Center
1313 West Seminary
(608) 647-6161

Dr. Kane and Dr. Choithani have developed a Microsoft PowerPoint presentation that can be used by physicians to train other physicians. It is consistent with the content in this guideline and utilizes some of the same resources. Contact them directly to obtain the most up to date version.

Key Points for Sustaining Physician Involvement

1. How to promote physician interest:

    a) Continuing Education Units (CEUs) attract physicians.

    b) Interest increases if nursing home residents are a large part of his/her practice.

    c) Most physicians want to "do the right thing" and minimizing restraints is the new right thing.

    d) Early involvement by physicians who practice at the facility and their input to the facility's training team is vital. Resolve issues prior to training.

    e) A positive training environment is essential to secure physician attendance, especially if giving training to a group.

    f) Vendors may be considered for contributing to this positive training environment, but they should not be vendors who promote restraints. "Devices" can be restraints for some individuals, and anything can be a potential hazard, especially for residents with cognitive impairments or uncontrolled physical movements.

2. Wisconsin Association of Medical Directors (WAMD) collaboration:

    a) Physicians from WAMD have collaborated on and reviewed the content of this guideline.

b) Watch the WAMD Newsletter for articles related to alternatives to restraints. Every medical director in WI gets the newsletter regardless of membership status.

c) The Web pages of the National and the Wisconsin physician's associations are listed in the Appendix and will keep you updated.

d) The WAMD plans to address this issue at seminars.

3. Each facility's training team needs to open and maintain effective dialog between physicians and nursing home staff about this issue:

a) Facilitate face to face meetings between physicians and nursing home staff.

b) Educate physicians and nursing home staff about the importance of good physician-nursing home communication.

4. How to reach physicians with educational efforts:

a) Volunteer to speak at hospital "Grand Rounds" or "Geriatric Grand Rounds" – type meetings.

b) Nursing home training teams should try to "get on the schedule" at hospitals for updates on this issue at least once per year.

c) Share with physicians any recently published clinical research from journals that support restraint elimination.

d) Share your own progress in the facility, especially if supported with data on the results of your prevention strategies and successes, as well as individual resident success stories.

e) Volunteer for presentations at any physician-attended educational conferences.

f) Watch for WAMD conferences and newsletters and send information and articles to WAMD for possible inclusion in its newsletter when you have had success that would be helpful to others.

g) Quarterly physician staff meetings of physician groups and clinics are usually held in the local areas. Network to get "on the agenda" for these too, at least once a year, and share information as described above.

5. What do physicians want to know?

a) Hard, scientific data about restraint reduction efforts, the results of restraint reduction by researchers and the results of restraint reduction in *your* nursing home

b) Facts from professional publications/articles on restraint reduction, fall and injury prevention, etc.

c) Alternatives that solve the resident's issues in lieu of a restraint or a side rail.

d) Measures that will keep the resident safe *without* a restraint or a side rail.

e) How to get rid of a restraint that is being used.

f) What the Federal and State regulations actually say and how they are interpreted.

g) Importance of *stopping* any restraint orders when the medical symptom resolves. (Does the facility have a policy on how long restraint orders are to be in effect?)

h) Has there been an interdisciplinary review of the resident? If so, when was the review and what were the results?

i) When will the interdisciplinary team re-evaluate the resident?

6. Clarify the physician's authority over the resident's medical care versus nursing interventions that nursing staff or family might desire but are ***not required to treat*** a resident's medical symptom.

   Use the handout "Questions Physicians Should Ask When a Restraint Order is Requested" in Appendix B. This is designed to improve communication between the physician and the facility staff members about the resident's assessments so that restraints can be avoided, minimized, or eliminated.

7. How can we assist physicians, nursing home and hospital staff to work together as a team?

   a) Talk to the medical director of the nursing home and encourage him or her to play a key role in this effort. Also contact local physician staff to discuss educational opportunities you could arrange in your community.

   b) Bringing in a physician "from the outside" who is an expert speaker in avoiding restraints can benefit both the physicians and the providers. Physicians generally receive training best from other physicians who are respected experts in their fields. The workgroup that developed this guideline suggests Dr. Eric Tangalos of Rochester, Minnesota as a good speaker on this subject.

8. Explore your community for physicians who are willing to give group talks or are willing to talk individually to other physicians. They will be a resource regarding resident care issues, especially when difficult situations come up. If you find willing individuals, mobilize this resource in your community. Your local Ombudsman may be aware of such physicians.

9. Physicians who serve as Medical Directors and are willing to share their strategies for success with other Medical Directors are valuable. This could be especially helpful to other physicians practicing in a nursing home or hospital who are "at odds" with a nursing home or hospital staff over restraint reduction/elimination issues. The WAMD may also be able to help with this through its newsletter and Web page.

Learning Outcomes:

Not all of these outcomes can be met in one training session. Instead, the participants gradually achieve these outcomes in an ongoing learning process. The desired outcomes should guide the ongoing process of working with physicians toward restraint elimination.

Physician participants will:

1. Carry out their role in providing medical care that discourages restraints, minimizes the time for restraints that are a temporarily required and promotes alternatives to restraints.

2. Know the hospital and nursing home federal and state regulations regarding patient and resident care, especially those related to limiting restraints.

3. Understand and support the decision-making process of the interdisciplinary team within the collaborative model of medical practice in institutions.

4. Develop improved methods of talking with patients and families about the risks of restraints and the benefits of restraint avoidance. Improved communication can help families overcome their fears and better understand why restraints are avoided in hospitals, nursing homes and other health and residential care settings.

5. Avoid or minimize restraints during hospitalization and try to discharge persons to nursing homes and other settings without restraints.

6. Encourage other physicians to avoid restraints and promote alternatives, especially when serving in the role of Medical Director of a nursing home.

TRAINING OUTLINE:
PHYSICIAN EDUCATION

Unfortunately, deaths still occur in nursing homes due to strangulation and asphyxiation, especially when residents are restrained or side rails are used. There are usually one to three occurrences in Wisconsin each year, all involving side rails, and about 200 such deaths per year across the United States. These deaths are unnatural and undignified. An article published in the WAMD Newsletter in the spring of 1999 explains physicians' crucial role in helping to eliminate the concept that restraints are safety devices and in helping others learn that most nursing home residents are safer out of restraints than in them.

Bureau of Quality Assurance memo #99-053 from September 1999 provides information about the FDA warning about the dangers of side rails and describes the relevant regulations for various providers. During the summer of 1999, a resident died in a nursing home during each of the months of June, July and August due to entanglement in bed side rails.

1. Review the "Becoming A Trainer" module before proceeding.

2. Secure the support of administration.

3. Review the training content with physicians in mind.

4. The team may need to assess each physician to be trained and develop an individualized approach, especially if there are conflicts. Discuss and consider:

   a) Medical Director's perspective
   b) Other referring physicians
   c) On-call physicians
   d) Nurse practitioners/physician extenders

5. Develop a plan that offers group or individual physician training, depending upon the need.

6. Recruit physician experts to train, or develop a team consisting of physicians, nurses, social workers, activity professionals, therapists, etc. Physicians and hospital staff will benefit from some of the same content; assess the audience and adjust the training content accordingly. Opportunities to provide group education to physicians should be used whenever possible. However, by using an individualized approach, the same concepts can be conveyed on a one-to-one basis with physicians.

7. If group presentations are arranged, this approach can be used:

   a) Pre-Training questionnaire - This may be done in a "paper and pencil format" with discussion, or put up on a screen and reviewed using an informal "show of hands' and discussion format. If modern technology is available, the questionnaire may be done with electronic responses. For physician audiences, use either the comprehensive pre-test/post-test or the short form if time is limited.

   b) Discuss and prioritize the issues from the pre-test questions that are most important or contentious for the audience. Keep the learning objectives in mind. Be sure to address the barriers that physicians see in reducing restraints.

   c) Provide physicians with up-to-date professional journal and research articles that document successful restraint reduction and the negative effects of restraint utilization, especially those in the Recommended Reading list and up-to-date ones from the HCFA Web site:

      http://www.hcfa.gov

   d) Other written, research-based resources that address the correct utilization of medications are helpful, including information about any appropriate psychotropic medications that are effective for particular clinical conditions. Chemical *restraints* are inappropriate in long term care; however, the proper utilization of psychoactive medications for psychiatric illnesses, particularly depression, is altogether *appropriate* and *desired.* Depression in the elderly is often under-diagnosed; however, side effects of medications must always be considered when prescribing for a frail elderly person.

   e) Review and discuss the overheads/handouts in Appendix B to address the issues of your audience:

      - Examples of Benefits of Individualized Care & Restraint Reduction
      - Examples of Risks and Side Effects of Restraint Use
      - Legal Decision-Making
      - Answering Tough Questions

- Questions Physicians Should Ask When a Restraint Order is Requested

f) Review the post-training questionnaire and discuss the answers with your audience, using either a paper and pencil format, orally with overheads and discussion or electronically. The questionnaire should enhance learning but also be a way to measure and document the effectiveness of your training. If you do not have actual "test scores" to measure your training results, establish a way of measuring the difference in participant scores prior to and after your training, even if it is just a count of the "show of hands." If people still do not have the "right" answers on the post-test, follow-up on these topics until the audience has a good understanding or work with individuals one-on-one after the group session.

8. If physicians and nursing home staff develop a commitment to on-going dialog about issues, that may be the most important outcome of training. One way to continue communication is through an ongoing effort to share journal articles and medical research with each other. Keep physicians informed about any research in your facility, your data on restraint reduction and any positive results with restraint reduction. **Physicians rely a great deal upon the creativity of hospital and nursing home staff to keep the patient or resident safe, with or without restraints or side rails.**

9. Discussions that address the legal aspects of physician's orders for medical care and the role of the interdisciplinary team in providing for the safety and care of residents and patients need to be included.

10. "Physicians and Restraint-free Care of the Elderly" is an audiotape from the HCFA Video Series "Everyone Wins." The guideline development physician team members reviewed this tape and they think it is a good resource tape that physicians might listen to in the car, but it is not appropriate for group training.

Physicians may respond positively to the "Everyone Wins" video for families, but there is no video in the series specifically for physicians. View the videos with your physician's personalities in mind and the concepts that you want to emphasize before deciding whether or not to use a video for physician training.

Educating Hospital Staff

Providing A Quality Life While Avoiding Restraints

EDUCATING HOSPITAL STAFF: PROVIDING A QUALITY LIFE WHILE AVOIDING RESTRAINTS

This module is designed for nursing home staff to use for joint training of hospital staff, particularly in the hospitals that refer residents to them.

Pre-training Planning:

1. Evaluate whether or not your community needs this training module. Even if there is no friction between the hospital and the nursing home, training on this critical subject may improve the quality of life for your residents when they go to the hospital. The interaction is also a good opportunity to reach out and help hospital staff understand the new paradigm shift to restraint avoidance.

2. If there are discharge planning issues, call and offer this inservice to present an opportunity to improve information sharing between the hospital and the nursing home.

3. This training provides for discussions and training for hospital staff who may not understand the risks and negative effects of restraints and the positive effects of avoiding restraints.

Learning Outcomes:

Not all of the outcomes can be met in one training session. Instead, the participants gradually achieve the outcomes in an ongoing learning process. Prioritize the outcomes in order to meet the audience's needs and concerns.

Hospital staff participants will:

1. Identify their role in setting an example for other professionals, families and the public by providing quality care while avoiding restraints.

2. Implement creative ways of caring for individuals in the acute care setting while avoiding restraints.

3. Recognize the relevant hospital and nursing home federal and state regulations regarding patient and resident care, especially in the areas related to the limiting the use of restraints.

4. Plan ahead for the discharge of individuals who will be going to nursing homes or other community settings so that caring for them does not depend upon the use of restraints.

5. Implement approaches for working *with* physicians in acute care settings to help them avoid restraints with their hospitalized patients and to help physicians educate family members about the risks of restraints and the benefits of restraint avoidance.

TRAINING OUTLINE:
EDUCATING HOSPITAL STAFF

Training hospital staff is most effective if done jointly with hospital supervisory, administrative and educational staff.

1. Administer pre-training questionnaire in written or oral format. (See "Becoming a Trainer", Appendix A)

2. Discuss the questionnaire, answer any burning questions and explain that you will discuss the issue more during the training. Then be certain to spend time on that subject.

3. Discuss the clinical experience and the current responsibilities of the participants. Ask them to talk about what they originally were taught about restraints and how this concept affects their clinical practice now.

4. Discuss what patient conditions result in the use of restraints. Where in the hospital are patients restrained, when, with what types of restraints and for how long? (Consider providing a copy of the current hospital policy or procedure for restraint use for discussion. Do this only if you can coordinate this with hospital supervisory staff who can be available for questions/discussion.) With hospital supervisory staff, present suggested alternatives for situations that are resulting in restraints in the hospital and encourage staff and a supervisory staff to try alternative approaches.

5. Discuss the topics in the learning outcomes and provide participants with a copy. Assess **which topics the participants want to spend the most time on and prioritize accordingly**:

    - Their role in setting an example for others
    - Their expertise in creative care of hospitalized persons – what have participants creatively done with patients that enabled them to avoid using a restraint?
    - Relevant federal and state hospital and nursing home regulations.
    - Discharge Planning and early elimination of any restraints temporarily needed in the hospital to provide medical care.
    - Approaches to working with physicians in avoiding restraints.
    - Approaches to working with patients and families in avoiding restraints.

6. Depending upon your audience, consider using a video here. You may want to use a video in the Everyone Wins series, especially the one designed for **families**, or the one designed for **management**, depending on the priority needs of your audience. The videos are filmed in the nursing home setting, so assess beforehand whether or not your audience will have a negative reaction to this concept. This will vary from person to person. You can explain that seeing how restraints are approached today in nursing homes, may help hospital staff adapt some of these same concepts and perceptions. Watch the video for families and the one for management before you get to this point (see the "Becoming a Trainer" module). Consider using them to emphasize the benefits of avoiding restraints and the risks of using them frequently in hospitals where

families have learned to see restraints and side rails as safety devices.

7. Consider using an additional guest co-trainer, such as the Ombudsman in your area. The Ombudsman can explain how they can assist with these issues. Their schedules fill very fast, so plan ahead.

8. Experienced nursing home staff can describe to hospital staff a "typical" resident scenario to show how a resident experienced declines during hospitalization that hospital staff members may have prevented if some things had been done differently. Discuss the importance of ambulating persons in the hospital, having them out of bed for meals and otherwise preserving their functional level, despite the typical problems of IV poles, weakness, etc. Emphasize how maintaining a patient's functional level makes the job of the hospital staff easier, shortens the hospital stay, decreases agitation and prevents accidental deaths in side rails. If possible, use a real patient experience (but protect confidentiality).

9. Inform hospital staff that the nursing home and the long term care community are both educating consumers and family members on the importance of this kind of individualized care for the elderly and the disabled when they are hospitalized. Providing individualized care in the hospital will show that hospitals continue to be "on the cutting edge" with regards to maintaining the safety *and* functional level of their patients.

10. Review the ***current*** federal Hospital Conditions of Participation and the state hospital regulations. This should be done by and *with* the hospital administrative/training staff. Summarize current regulations in an overhead and make sure everyone receives a paper copy. Since regulations change over time, they are not provided in this guideline. Provide a copy of the current federal nursing home regulations that address rights, restraints, etc., with the Guidance to Surveyors sections included. Within the Guidance to Surveyors section, the definition of a restraint is clarified and probes for evaluating restraints are listed. Provide a copy of the current state regulations that address the resident's rights and use of restraint issues. (Call the Bureau of Quality Assurance at (608) 267-1446 to obtain current federal and state regulations for hospitals and nursing homes.)

11. Define what constitutes a restraint. See BQA memo 98-003, dated April 21, 1998 for reference. If newer BQA memos addressing this subject are issued after the publication of this guideline, utilize them as a reference. They will be updated on the Department's web site at:

    http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

12. Explain the concept of "That was then; this is now," regarding today's professional view on the dangers of restraints and side rails. The recommended reading appendix can be utilized here for articles, pictures and data.

13. List the risks of restraint use and discuss the possible harm that can happen in a nursing home or hospital. Have participants verbalize what the risks are. You can write them on a blackboard or overhead, or use an overhead/handout in Appendix B. Encourage participants to share clinical experiences or experiences with family members for examples of when they have seen risks occur. If there are some they do not identify, add them and discuss them. Use the handouts in Appendix B as a reference and to stimulate discussion if audience participation is not active. Pictures in the NCCNHR booklet "Avoiding Physical Restraint Use" can be effective for those

who cannot picture side rail entrapment.

14. List the negative physical effects of restraints and encourage participants to describe any negative effects they have seen.

15. Identify the benefits of avoiding restraints using participation, blackboard, the handout, etc.

16. Explain how families are learning to question the unnecessary use of restraints in both nursing homes and hospitals because of an effort to reduce restraints.

17. Solicit and discuss suggestions for ways to maintain functional levels during hospitalizations, such as:
    a) Phoning the nursing home to find out what the person's functional level was prior to the decline or illness that lead to hospitalization.

    b) Asking for the nursing home to identify a particular person to ask for and the best hours to contact the nursing home. If the hospital calls and gets someone in the nursing home who is "filling in" and not familiar with the resident, the caller should ask who the best person is to talk to about the resident. Someone should then call the hospital back with this resident information. The MDS data on the resident can help with this.

    c) Note to trainer: Before making this "promise," be sure nursing home staff are all instructed about the importance of good communication with hospital staff. Also make certain all staff know how to "handle" these calls and understand the importance of continuity of care. When someone says, "I've never seen this resident before" instead of offering to be helpful, the caller is immediately discouraged. The nursing home wants to avoid this outcome and get the information to the hospital staff when a resident is hospitalized.

    d) Have participants identify ways to maintain these functions for hospitalized individuals:
       - Oral re-hydration (To prevent IV's or get them "D/C'd" sooner)
       - Maintaining nutrition and self-feeding ability by getting them out of bed for meals and assisting them but not discouraging their capabilities
       - Ambulating
       - Toileting
       - General ADLs and usual daily routine
       - Communication techniques that work
       - Maintaining cognitive function and reducing meaningless environmental stimuli
       - Maintaining decision-making and participation in their care & treatment
       - Preserving dignity
       - Positioning/Turning/Transferring
       - Psychosocial well-being & emotional/spiritual support
       - Family involvement
       - Other ideas from participants

18. Discuss any barriers to carrying out goals in the hospital regarding restraint minimization and identify ways to overcome these barriers. Facilitate development of action plans for each barrier they identify and write them on a flip chart, blackboard or overhead ("What can we do to overcome this?") Have participants verbally contract about what they can do or with whom they

can make contact to work on breaking down barriers.

19. Discuss the importance of working as an interdisciplinary team to overcome obstacles, and emphasize working *within* the hospital systems and organizational structure while still thinking "outside the box."

20. Discuss any physician issues and develop joint plans to correct any issues using the same interdisciplinary process. The section on physician education can help with this.

21. Point out that the use of chemical *restraints* is not an acceptable alternative. However, explain that appropriate use of psychotropic medications for treating the symptoms of *psychiatric* illnesses, especially depression, does *not* meet the definition of chemical restraints.

22. If any sedation is needed to complete a medical treatment, ensure that this is only done on a limited basis and for no longer than is necessary.

23. Discuss discharge planning and how to facilitate getting residents back to the nursing home, CBRF, or home care agency without physical or chemical restraints.

24. Administer the post-training questionnaire verbally or in writing and discuss any remaining issues.

25. Allow questions and answers throughout the training, but be *sure* to encourage them after the post-training questionnaire.

26. Review the action plans from the flip chart/blackboard/overhead, and emphasize positive suggestions that have been made. Encourage participants to verbalize what they can do differently. Send them out on an uplifting note and encourage them to "make a difference" in their hospital.

27. Have them complete a training evaluation.

28. Review their pre- and post-training questionnaire results, their participation in the training and their action plans. Save them or jot down the results while they are fresh in your mind. Review their evaluations and report to your training team and leadership.

29. Give a positive report to the hospital leadership and thank them, verbally and in writing, for the opportunity to do the training. Invite them to contact you for follow-up. Describe your availability for ongoing refresher education or assisting them with new employee education in avoiding restraints. Consult your administration in advance about what your level of commitment can be.

30. Report to your facility leadership about the success of the training and thank them for supporting you in this training effort. Confirm with them your long-range goals.

Educating Nursing Home Staff

Providing A Quality Life While Avoiding Restraints

EDUCATING NURSING HOME STAFF: PROVIDING A QUALITY LIFE WHILE AVOIDING RESTRAINTS

This section is for nursing home staff to use for facility staff training. The videos, training guides and handouts in the video series "Everyone Wins" can be used to complement this training.

Learning Outcomes:

These learning outcomes are not intended for one training session. They are intended for six or more training sessions spread over time and repeated on an ongoing basis as new staff members are added and changes occur. Prioritize the outcomes to meet the staff's needs and concerns.

Facility staff will:

1. Recognize that restraints and side rails are not benign safety devices and that they create additional hazards for residents. It takes staff vigilance and interventions to protect residents from the dangers associated with restraints and side rails.

2. Develop a working knowledge of the federal and state regulations regarding resident care. Understand the regulations related to the resident's right to be **free of restraints** and the importance of following the quality of life and quality of care regulations. Also identify those limited circumstances under which a restraint may be necessary as a temporary measure due to a medical symptom.

3. Recognize that there is never "an end point" when it comes to providing care that avoids unnecessary restraints. We are always looking for better ways to meet the needs of every resident, to keep each of them restraint free, and to keep them safe if restraints must be used. Assessment and Care Planning are part of a *seamless, continuous process*, not an event.

4. Understand the critical nature of providing for the safety of any resident who is restrained, and understand the legal ramifications and the potential risks for the staff if things go wrong and a resident is injured or killed due to the restraint or side rail.

5. Inform themselves very well about each resident, including what the resident was like as a person before this decline, what the resident's interests are, and what helps the resident feel safe, secure and comfortable. This knowledge is necessary in order to achieve the highest quality of life for every resident.

6. Recognize that the ***interdisciplinary team approach (the whole team)*** is essential in order to achieve a quality life for individuals. This includes all shifts and all disciplines, activity persons, etc. Everyone needs to keep asking everyone else "Why?" multiple times until the team can agree on what care measures and activities to put into place for each resident.

7. Recognize the importance of truly **empowering the front line staff** to be creative in what makes a difference for residents, as these are the people who know the resident best. The persons who are most apt to be able to identify creative ways to avoid restraints for residents are the nursing assistants who are with the resident the most.

8. Involve the entire interdisciplinary team in the comprehensive assessment of the resident, the education of the resident and the family, and the determination of alternative care methods that

avoid restraint.

9. Understand that creative, preventative interventions, rather than restraints, foster resident independence and make the work of the staff easier and more rewarding.

10. Understand and consistently *implement* viewing the resident from a holistic perspective. Do not focus only on the devices or the restraint reduction *committee* or whether or not the use of a restraint is "justified."

11. Understand how to correctly identify, count, document and accurately report the number of residents who are restrained.

12. Develop consistent **proactive** teaching and care approaches that help residents and families overcome their fears, especially before or upon admission, and whenever there is a situation in which restraints might have traditionally been used.

13. Develop a continuous quality improvement commitment (which can have a variety of labels depending upon facility policy) that fosters the highest practicable quality of life for each resident and also keeps the number of restrained residents as low as possible.

14. Ensure that this commitment also limits the use of necessary restraints. If, as a last resort, staff utilize a restraint for a medical symptom, the restraint should allow the resident to achieve his or her highest practicable quality of life. Also, if restraints need to be utilized as a last resort, any time frame in which a resident uses restraints must be kept to a minimum. **Most importantly, any and all needed supervision and safety precautions always should be in place to prevent accidents, injuries or deaths from any temporary restraints, or from devices such as side rails, regardless of whether they meet the definition of a restraint.**

Use Today's Terminology

If you have entities in your facility such as "The Restraint Reduction Program" or "The Restraint Committee," consider re-naming them things like "The Quality of Life Committee" or some other creative title that better exemplifies your mission of promoting quality resident care. Some facilities report that they use the terminology "Restorative Care Committee" when dealing with these kinds of resident issues. Within each individual resident's assessment and care-planning process, be sure your focus is on *maximizing the resident's potential without utilizing restraints or siderails*, rather than focusing on counting or justifying the devices you utilize.

Through an improved resident assessment and care planning process, you will be assessing and evaluating interventions for *each* resident and there may not need to be a "Restraint Reduction Committee". If everyone focuses on each individual resident's needs, not on devices, the creativity within your staff **will** be able to extinguish the use of unnecessary restraints. Extinguish language that restricts creative thinking. (For example, we once called people "patients," and now we call them "residents," "persons" or "individuals," recognizing their uniqueness.) Stop yourself, and help others stop always automatically using the word "restraint" and focus on positive, preventative interventions with residents. "Let's explore what we can do, Mr. Jones, to help you stay safe and to help you feel comfortable and secure."

Anticipate, anticipate, and anticipate! Front-line nurse aide staff have the best ideas about what to do to make people safe. These people must be an integral part of your assessment and care planning process and are the keys to good, safe resident care. Empower them.

Focus on Your Strengths & the Strengths of the Resident, Using:

- The Interdisciplinary Comprehensive Assessment of each resident.
- The Interdisciplinary Care Planning Process.
- A focus on the highest practicable quality of life for residents.
- Your continuous quality improvement system, direct care supervision and administrative involvement to keep the "threshold" of restraints absent or low, to reduce the time residents need restraints, and to keep residents safe when using unavoidable restraints.
- You are responsible for each individual resident, not just the "Restraint Reduction Program."
- Celebrate successes with using alternatives to restraints, and help staff, residents and families have successes without restraint use. Provide them with rewards and incentives, and, in addition, help them develop an internal sense of accomplishment by encouraging them to feel good inside because of their success. Let them know their efforts make a difference and are appreciated, even by residents who may not be able to express themselves.

While Improving Your Training and Care Provisions:

- Use the correct definitions in identifying any remaining restraints; and
- Correctly record and report any data.

BQA (Bureau of Quality Assurance) Memo 98-003 explains this in detail.

BQA memos are available at the DHFS (Department of Health and Family Services) web site at:

http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

TRAINING OUTLINE:
NURSING HOME STAFF

Training Planning:

1. Assess the needs of the specific staff members, using specific resident examples and issues that have occurred in the facility. This should be done by an interdisciplinary team.

2. Prioritize the issues and address them systematically, using the learning outcomes in the guideline. It will take time to address all the learning outcomes, as it may mean changing many attitudes and perhaps the whole culture of the facility. This takes time and the team needs to utilize a long-range approach, including an on-going plan for newly employed staff.

3. Educate staff to think critically about each resident and how their care can be individualized.

4. Use the six videos in the series and the handouts in the appendices to bring about changes. These should not be used too closely together but spread over a period of time, addressing the priorities of your resident population.

5. Having copies of journal articles available for staff to read is helpful. Facilities are responsible for adhering to copyright laws. Hospital and local librarians can advise you. Some facilities keep a notebook with a single copy that staff can read and ask questions about.

Training Content:

1. Develop a training outline by prioritizing the learning outcomes for your staff and key points from the module. Divide them into workable groupings for training sessions. (See sample outline in Appendix A.)
   a) Viewing restraints as hazards rather than safety devices
   b) Definitions along with federal and state regulations
   c) The need for the process of ongoing assessment and care planning
   d) Potential for negative outcomes from improper use of restraints
   e) Knowing the individual resident very well
   f) Using an interdisciplinary approach and keeping everyone involved
   g) Empowering “front-line” staff
   h) Using creative, preventative interventions
   i) Promoting resident independence makes their work easier in the long run
   j) Focusing on the care of the resident in a holistic sense
   k) Correct counting, documenting and reporting for any residents that remain restrained
   l) Proactively promoting restraint avoidance with residents and families
   m) Supervision to prevent accidents if residents are restrained or if they have side rails up
   n) Continuous quality improvement efforts, regardless of what it is called in your facility
   o) Using today’s terminology
   p) Anticipating resident needs
   q) Focusing on the strengths of the resident

2. Use videos and handouts in Appendix B to complement training sessions, if possible.

APPENDIX A

Becoming A Trainer

Providing A Quality Life While Avoiding Restraints

BECOMING A TRAINER:
PROVIDING A QUALITY LIFE WHILE AVOIDING RESTRAINTS

This module is for people who are preparing to provide training on this subject, especially if they are new to long term care or are new to the role of trainer. It can be used by a person in leadership to train a trainer, or a trainer can use it for self-study.

Learning Outcomes:

Not all of these outcomes can be met in one training session. Instead, the participants will achieve the outcomes in an ongoing learning process. Prioritize the outcomes in order to meet the audience's needs.

Trainers will:

1. Identify and perform successful public presentation skills.
2. Identify their training role on providing quality care in the area of restraint avoidance.
3. Know and teach the federal and state regulations related to resident care, especially those governing resident's rights, assessment and care planning, quality of life, quality of care and safety requirements, as well as those limiting the use of restraints to only what regulation allows.
4. Listen to the perspective of others regarding restraints and help them better understand how to provide the best in individualized care for residents in situations that may have led to the use of restraints in the past.
5. Identify positive, helpful resources and resource people, including a mentor who has successfully reduced or eliminated the use of inappropriate restraints.
6. Contribute to the continuous quality improvement program in the facility, especially in the area of continuing education on quality of life issues and training on limiting the use of restraining devices and ensuring that their use is safe and appropriate.

GETTING THE JOB DONE

Becoming a trainer on care interventions that replace restraints can be a challenge in any setting. Review the learning outcomes for each training audience to focus on what you are trying to accomplish.

- **FIND A MENTOR**

  It takes more than one person to change the culture of a facility and a community on this issue. It will be very helpful if you seek mentoring support from supervisors and/or peers, preferably both. Look into your circle of peers and find allies who can support and assist you in this endeavor. One of the greatest "boosts" in becoming a trainer on a sensitive and controversial topic like restraints is finding a mentor or a mentoring team that has achieved success in reducing restraints. You will benefit from developing focused relationships with residents and families who have been involved with these issues and have been successful in restraint avoidance. These family members can be your greatest advocates in helping other families and

can provide that special sharing of personal experience with your training audience. Your local Ombudsman can also support you in your efforts and provide you with resources and assistance.

- **USE UP-TO-DATE RESOURCES**

  If you have not recently read professional journal articles on fall prevention and restraint reduction, be sure to do so. It will assist you in developing insight about the issues. An appendix is provided in the guideline that gives you some basic resources. You will also want to keep up with the current professional literature, either through your employer, your own subscriptions, your local medical library or internet resources. Mentors and supervisors can help you with your self-assessment process, guide and direct you and help you gain confidence in handling issues that can sometimes be tough.

- **EXPLORE YOUR OWN PERSPECTIVES**

  Before you can train others on providing care without restraints, you must first explore your own personal views and the history of your education regarding restraints. If you were taught that restraints are benign safety devices that should always be utilized, you may need to do a great deal of reading and talking with other professionals in order to prepare for the topic. The current understanding of restraints now focuses on the self-determination rights of people and their right to be free of restraints. It also stresses the importance of residents being protected from any injury as a result of being restrained. It requires looking at things from the individual's point of view and may require you to *unlearn* some of your past training or experience.

- **COMMIT TO THE INTERDISCIPLINARY TEAM APPROACH**

  Are you committed to the interdisciplinary team approach for the resident assessment and care planning process? This team approach is of the utmost importance if residents are going to be kept safe and allowed to function at their highest practicable levels without restraints. You must focus on the resident's strengths and capabilities, and recognize that an intervention must *do something beneficial **for** a resident* before it is used, even temporarily. An interdisciplinary approach to training will enhance your results and will be more satisfying for trainers. This is a subject that should not be handled alone by only one discipline.

- **SECURE THE COMMITTED SUPPORT OF ADMINISTRATION**

  There must be a firm commitment on the part of administration at all levels before training on avoiding restraints can be successful. If you have individuals, groups or boards who do not have an understanding of the paradigm shift to avoiding restraints, assess what will have an impact on them and mobilize those resources. Reading professional journal articles may be effective for some individuals. Others will respond to hearing from others **in their peer group** who have been successful in reducing restraints and have gained the benefit of having residents in the facility who are more independent. Anyone who is in administration is always fearful of increased costs. Studies show that restraint-free care does not increase the cost of care, and journal articles can often help administration gain awareness of other people's success. Watch the video "The Management Perspective" from the video series "Everyone Wins" to help you develop your approach to management. Talk to your mentors, supervisors and resource people to help you gain administrative support if it is not yet committed. If their support is

encouraging, let them know how valuable their support is, keep them informed, and be sure any positive feedback is channeled to them. Many nursing homes have enhanced their reputation with residents, families and their communities by reducing restraints.

- **DO A THOROUGH ASSESSMENT OF YOUR LEARNERS SO YOU CAN PROVIDE FOCUSED TRAINING**

  Focused training does not mean rigid. Be sure that you thoroughly assess your training audience and provide training that addresses the issues most important to them. Give them opportunities to apply their new knowledge right away. Adults frequently like actual case studies in which they can brainstorm together, select interventions and develop care plan approaches, applying what they have learned right away. Working through case studies provides the learner with a sense of accomplishment and fosters retention of the concepts and skills.

- **SELECT LEARNING TECHNIQUES BEST SUITED TO YOUR LEARNERS**

  Today's adult learners bring a great deal to the learning setting, and they learn best when they apply what they are learning as the training progresses. Many learners today are also more visually oriented. Use quality modern media such as videos, interactive videos, slides, Microsoft PowerPoint presentations, and overheads as much as possible. Study the ways people learn as part of your learning process and remember that you will probably have a variety of preferred learning styles in your audience. The ability to appeal to every type of learner will be necessary to ensure the success of your training sessions. Keep in mind that almost everyone learns best by immediately applying what they learn. Resources on "How to Teach Adults" can be very helpful to you.

- **POLISH UP YOUR LISTENING SKILLS & ASSESS YOUR LEARNERS**

  The most critical skill a trainer possesses is the ability to listen to the concerns of the individuals who are being trained. Ascertain what attitudes and perceptions your audience has about being trained on reducing restraints. Focus your training on getting audience members *to where they need to be* regarding this important issue. Saving resident's lives, enhancing the quality of their lives, and ensuring their safety in the nursing home environment depends upon everyone being committed to individualized, safe resident care. This is true for everyone, but it is extremely critical for family members and residents themselves. Remember what your past perceptions were if you were taught that restraints were benign safety devices. Individuals to whom you are providing training will be in various places along the learning curve regarding avoidance of restraints. Holding group discussions, *listening* to them *throughout* the session and reviewing the pre-training questionnaire will help you assess exactly how to met their training needs.

- **WATCH THE VIDEOS AND READ THE ARTICLES, HANDOUTS AND MODULES IN THE TRAINING GUIDELINE**

  The guideline resources will enable you to see the entire training package and give you a feel for how each module of the training packet will affect each person for whom it is targeted. Seek clarification from your mentor or supervisor for any questions or concerns that you have. If neither of you know the answer, do not struggle with it; seek someone who can help you find answers. There are many health care institutions and experts who are doing clinical research in

the care of individuals with complex problems. They can give you real-life answers or help you find the answers yourself.

- **LEARN BASIC TRAINING AND PRESENTATION SKILLS**

  If you do not have a lot of previous experience in doing training, you may want to attend courses that prepare you to be a trainer. An excellent textbook that can assist you is The Art of Public Speaking by Stephen E. Lucas of UW-Madison. Multiple books and journal articles will assist you in developing training skills. Your supervisor or mentor will be able to advise you about what is available.

- **HAVE FUN**

  There is ample evidence that people learn much better when they have fun, and you will get "more miles to the gallon" from your own tank if you have fun with your training. Think of your training audience as people who are guests in your home. You want them to leave feeling comfortable, exhilarated and wanting to come back again. Using humor in a training session is helpful, but it must always be done carefully so that no one takes any offense. Do some reading about how to use humor correctly in the workplace and keep yourself and others having fun. Using color, flowers, fruit or a simple hard candy can provide special touches that let your audience know you care about them and your subject. Helping people learn and grow is an exciting experience that will give you a lot of rewards. "Laughter is energizing for the caregiver, it is contagious and humanizing, and it even has physical benefits." (Donna Scemons, Annals of Long-Term Care, January 1999).

- **ESTABLISH WAYS TO ASSESS YOUR AUDIENCE AND CARRY OUT TRAINING**

  Appendix B includes pre-training and post-training questionnaires in both a short and a comprehensive format. The questionnaires can be used in paper and pencil format. If you feel you need a softer approach, you may put them on an overhead and ask your audience for a "show of hands" before and after the training. It is good to read the questions out loud, especially if your audience does not have strong literacy skills. Always use the shorter version for families. The shorter version may be more appropriate for unlicensed staff than the comprehensive version. Be sure to jot down their answers so that you can compare before and after results to measure the effectiveness of your training. Discuss the pre-training questionnaire, answer any burning questions directly and explain that you will discuss the issues again during the training. Make a written or mental note and be sure to address these issues again. Use the audience's questions to focus the content of your training on the specific needs and concerns that are raised. Often people respond best when pre-tests and post-tests are used as a discussion tool. They give people opportunities to reward their own success and feel good about what they have learned and how they have grown. The pre- and post-questionnaires can also measure audience progress and learning. Hard data on the changes from pre-test scores to post-test scores is one kind of good evidence that your training is making a difference.

- **EVALUATE YOUR TRAINING**

  Candid evaluation forms that are simple to use are often helpful in showing how your audience is responding to your training and may help you improve your training methods. However, this does not measure learning. The pre-tests and post-tests are the way to measure learning. There is an example of a training evaluation form provided by Homme Home of Wittenberg; included in these materials, or you may have one of your own that you like to use. There are many ways to evaluate training and you will want to have a dynamic quality improvement approach to doing this. Texts, training courses and the advice of your supervisors and mentors can help with this.

- **ENSURE CONTINUITY OF THE TRAINING EFFORT**

  Always be sure that at least one person can be your "back-up"; someone who can step in and perform your training with the same skills and expertise that you bring to the process. This means having those persons involved *early on* so that they have the same commitment to the training that you have. Having an interdisciplinary training team enables many people to be involved and to support each other in this process. You have a richer and better training effort when the training responsibilities are shared by more than one discipline. When you have two or three persons who can provide this training, it is less likely that audiences will be "let down" if someone is out ill or not available when the need for training arises. **Keep pace with facility staff turnover and regularly repeat training sessions so new staff are kept informed and ongoing staff are "refreshed" with new information that becomes available to you.**

- **ESTABLISH A TEAM COMMITMENT TO A UNIFIED, ACHIEVABLE GOAL**

  All types of nursing home staff need to become committed to the *philosophy of individualized care.* This is especially true of direct care staff, nurses, aides and therapists. Many of these individuals were originally taught that a restraint is a benign safety device, and their personal experience may have led them to feel that they are protecting themselves and the resident when they apply a restraint. They may need to ***unlearn,*** and that is the most difficult kind of learning. Nurse aides and nurses must be given time to verbalize these feelings and must learn to support each other in the innovative measures needed for individualized resident care that prevents the use of restraints.

- **ANSWERING TOUGH QUESTIONS**

  When training on this subject, you will be subjected to some of the most challenging questions. You won't always have the answers. Never feel you have to give answers when you do not know them, but you *do* need to commit to finding the right answers for your learners. Many persons will be able to find their own "right answers" when the question is about their particular difficult resident or their family member. They may need your guidance in soul-searching for "the right thing to do." The answer keys for your pre-tests/post-tests are annotated with some explanations that should help you answer some of the tougher questions. There is also a handout in Appendix B that you can use to help answer tough questions. If you are struggling, your mentors, supervisors, administrators, physicians and other peer experts may know where to go for "the right answer." Ombudsmen can also help with these questions.

Some typical topics and tips for you:

1. Persons who are prone to falls may still fall if they are restrained, but the restraint or side rail adds an additional danger to the fall.

2. Improving the quality of the person's life by giving them more mobility may benefit the person far more than attempts to "tie them down".

3. Saying to your participant, "This is a common question that comes up," is a good method for encouraging them and other participants to feel comfortable in bringing up things they need to discuss.

4. Reading professional articles in the resource list will help you prepare to answer many questions.

5. Handouts in the Appendix will help you with the factual content. Stay in touch with newly published credible research and develop additional training materials based on that research.

Be Ready for Backlash.

The facilities who piloted this guideline experienced backlash and this may also happen to you. Many times persons with very strong personalities may have very traditional concepts about restraint usage. This is true for families, physicians, hospital or nursing home staff. Your ideas may not be well received and there may be some "rough sledding." You may even find that the number of restrained residents will increase temporarily when you start efforts to decrease restraints. Having the support of a mentor, an interdisciplinary team and your administration is critical for sustaining you in the face of adversity. Remember to **listen, listen and listen** again so that you can help individuals with these kinds of barriers come to a better understanding of today's concepts. If you can find the root origin of *their* perspective and help them to see how less restraint will *help* the situations about which they are most worried, they will often become staunch supporters in finding creative ways to have fewer restrained residents. Be ready for backlash, but don't stop your efforts. Secure more support, spread the responsibility for change to others in your support network, and persevere.

ADULT LEARNING PRINCIPLES

Much has been written about adult learning. Basically everyone, not just adults, learns better when the following kinds of principles are applied. If learning principles are unfamiliar to you, some additional reading may be indicated. These are some of the principles:

CHARACTERISTICS OF THE ADULT LEARNER

1. Adults are more mature and need to be treated with respect and acknowledgment of their abilities and needs, including recognizing the experience and knowledge they possess.

2. Adults bring a wealth of work experience and may have much practical experience that needs to be integrated into their learning.

3. Adults are more problem-oriented; they want to relate what they learn to practical issues and problems they face.

4. They like to have some control over their learning environment, such as self-paced activities, having some choices and flexibility.

5. Adults are typically more verbal in expressing their opinions.

6. They will usually need more opportunities to contribute to discussions and relate their personal experiences to the subject in order to feel they are learning.

7. They will usually be more motivated if they participate and they usually expect *immediate* benefits.

8. Adults usually want to understand clearly what an instructor expects; they especially want a good grade, or they have the potential to get upset and "block out" their learning. It is the trainer's responsibility to facilitate their learning and show them how they have learned.

VARIABLE LEARNING STYLES

Assessing learning styles helps facilitate learning. Most people use more than one learning style; two or more will fit most people. Usually a person has one dominant or preferred style and other supportive styles.

1. INDEPENDENCE - The ability to learn independently is variable; independent learning provides a great deal of flexibility and control. Independent learning will not occur unless the learner has a great deal of *internal discipline and the ability to concentrate.*

2. INTERACTION - The amount of social interaction needed for learning will vary. Many need a great deal of discussion to adapt; others will prefer to watch and listen and will follow a role model very quickly.

3. VISUAL LEARNING - Visual learners like to write down ideas because this helps them accumulate knowledge. Reading and writing or observing works better for them than having something explained. These are people who remember what they read in a book better than what they heard in class. People who prefer to look at lecture notes rather than listen to a tape are visual learners.

4. AUDITORY LEARNING - Auditory learners learn better by listening to someone or to a lecture or a tape. Demonstrations enhance this learning as well, and discussion groups are quite effective for auditory learners.

5. EXPERIMENTAL LEARNING - Experiential learners prefer learning through experience. Structured experiences and role-playing are effective, and they will learn well by having to give speeches, demonstrations and presentations. Guided study will work with these people.

6. TECHNOLOGICAL LEARNING - Technological learners have the ability to learn through TV, videos and computers. Technological opportunities such as computer-based educational programs, multimedia software programs, computer bulletin boards and computer conferencing work for these individuals.

In summary, the two most distinguishing characteristics to consider are the adult's usual need for autonomy of direction in the act of learning and the use of personal experience as a learning resource.

References:

Apps, Jerold W., Professor, Adult/Continuing Education, University of Wisconsin-Madison, Mastering the Teaching of Adults, Krieger Publishing Company, Malabar, Florida, 1991

Brookfield, Stephen D., Understanding and Facilitating Adult Learning, Jossey-Bass, Inc., San Francisco, CA 1986

Ludden, La Verne L., Ed.D. Back to School, A College Guide for Adults, Park Avenue Productions, Indianapolis, IN, 1996

DEVELOP & IMPLEMENT A CONTINUOUS QUALITY IMPROVEMENT SYSTEM

In an article published in the Wisconsin State Journal, Professor Joel Levin of the UW-Madison Department of Educational Psychology offered these 10 commandments of effective teaching. These concepts can enhance the framework for your Continuous Quality Improvement System. Use your resource people, especially staff, residents and families, to further develop your system.

Training should be:

Comprehensible, making the complex simple rather than needlessly complicating subjects.

Concrete, employing lots of examples, analogies and illustrations; including the skills students are expected to acquire.

Connected, relating new material to what students already know.

Coherent, with information presented in a logical, thoughtful fashion.

Concise, getting directly to the point, with overviews of the full lesson.

The teacher should be:

Committed and thoroughly devoted to the subject matter.

Current with the latest research in the field.

Challenging, fostering students' critical thinking and independent judgment.

Charismatic, making each class an "opening night" and putting on a top performance.

Caring, listening to students and giving them constructive advice, showing pride in their accomplishments.

TRAINING OUTLINE:
BECOMING A TRAINER

ADVANCE PREPARATION AND PLANNING:

1. Secure the support and guidance of administration.

2. Determine who can be on your training team. Strive for 3-4 persons from multiple disciplines, including nursing but not *just* nursing.

3. Discuss and determine the actual training priorities in your facility. Discuss actual residents and their issues to help you focus on where your efforts should be directed.

4. Select the persons who are most skilled and appropriate to train the different audiences you have identified as priorities. Physicians like training by other physicians, family members may benefit from sharing family experiences, etc.

5. The selected team members and their leadership should go through all the key components of the module. Implement the components and the elements listed below in the training process. The team and the leadership will need to decide when they are ready to present training. Set up logistics in advance to allow the team time to prepare once your facility's priorities are set.

THE TRAINING PROCESS:

1. The training process is to include the pre-training and post-training questionnaires. These are not to make people anxious; their purpose is to heighten interest. How they are introduced is critical in preventing unnecessary test anxiety. If people are too anxious, use a "soft" approach, explaining that the questionnaires measure how well the instructor gets the content across to the learner, instead of testing them. They may be discussed as a group using an overhead.

2. Lead an audience discussion to determine their attitudes and concerns regarding restraint avoidance issues.

3. The *learning outcomes in each module are to help focus your training.* Small group discussion of each topic is a good way for most adults to learn. Trainers should spend some time presenting the facts for each outcome and then allow participants to discuss the concepts and ask questions. Each module has a comprehensive training outline and a **Trainer's Basic Outline** is in the appendix. Once you have studied the comprehensive outlines, the basic training outline will probably be what you want to use in class.

4. Use visual aids and handouts interspersed with discussions. Overheads or Power Point presentations may enhance the learning, especially if there are more than two trainees.

5. Discuss an action plan for each learning outcome and take notes about what participants feel they can commit to doing:
   ("What can you do differently now regarding _____?")
   (A large flip chart is very helpful for this.)

6. Don't forget breaks if you are covering several topics in a session. As a rule, people can't sit for more than 50 minutes.

7. Administer the post-training questionnaire in either oral or written format, and discuss the questions and any remaining issues.

8. Review and discuss the action plan ideas that people have on the flip chart and determine a priority for what needs to be done. Write down who will be responsible for carrying out each priority. This enables people to leave your training with a sense of growth and a mission.

9. Have participants evaluate your training and review their post-training questionnaires.

10. After training, compare the scores of your participants on their preliminary questionnaire with their answers on the post-training questionnaire to help you evaluate their learning. You can do this if you use the paper and pencil method or if you ask for a show of hands using an overhead and record the results before and after training. You will also get a sense of this from their participation and the action plans they develop. Also review their input on the training evaluation.

11. Share the results of the training efforts with the training team and your leadership. Make any necessary adjustments to the training in preparation for the next class. Also be sure your training plan includes long-range planning as well as planning for the next class.

TRAINING EVALUATION FORM*

1. How valuable was today's session for you?

1	2	3	4	5
Not Valuable				VeryValuable

2. What are the most important things you learned today?

3. How do you intend to apply those ideas to your job or in your life outside of work?

4. Comments/Suggestions:

THANK YOU FOR YOUR FEEDBACK!!

*(Compliments of Homme Home for the Aging, Wittenberg, WI, or use your own.)

APPENDIX B

Training Resources

Providing A Quality Life While Avoiding Restraints

TRAINER'S BASIC OUTLINE*

I. INTRODUCTION

- Trainers
- Trainees
- Subject (See introduction in guideline, page 4.)

II. OVERVIEW OF OBJECTIVES

- Pre-training questionnaires (Basic or Comprehensive)
- Priority questions from audience
  (Focus on what material needs to be covered.)

III. BASIC CONTENT OPTIONS

- Video presentation recommended
- Review and discuss chosen handouts and pamphlets for your particular audience (see Appendix A)
  - Examples of Risks and Side Effects of Restraint Use
  - Benefits of Individualized Care and Freedom From Restraints
  - Legal Decision Making
  - Questions Physicians Should Ask When a Restraint Order is Requested

IV. SUMMARY

- Point out resource articles and resource people
- Help all learners identify one thing they are going to do
- Check with audience for remaining questions
  (Read "Answering Tough Questions" handout before class.)
- Post-training questionnaire (Same as above, Basic or Comprehensive)

V. TRAINING EVALUATION

VI. FOLLOW UP REPORT TO INVOLVED LEADERSHIP

*Comprehensive training outlines for each specific audience are in each section that addresses that audience.

APPENDIX B – VIDEO AND WRITTEN RESOURCES

"Everyone Wins" is a federal Health Care Financing Administration (HCFA) sponsored video series with adjunct materials developed with nursing homes in mind. It is recommended for utilization and integration into the overall training program. In all environments, nursing home and non-nursing home, a trainer should carefully review the videos and the materials to determine whether or not they are appropriate for your audience and your setting.

Some of the provider associations and each regional office of the Bureau of Quality Assurance in Wisconsin have copies of the training videos and materials that you can borrow. They are copyrighted and cannot be copied. Purchase costs are reasonable. For information about how to obtain your own copies of the training videos, call or write:

The Independent Production Fund
45 West 45th Street, New York, NY 10036
1-800-727-2470

"Everyone Wins" Content Highlights:

- "The Management Perspective" - A 16 minute video with resource guide:
    - Enhances facility's reputation and image
    - Does not cost more or require more staff
    - Does not increase resident risk or facility liability
    - An ongoing process of creative problem-solving
    - The care planning process is cyclical and continuous
    - Everyone must be involved
- "A Family Guide to Restraint-Free Care" - A 12-minute video plus a pamphlet for families. It is the only video that is sold separately.
    - The definition of a restraint
    - Restraints do not remove the risk of falls
    - Benefits of restraint-free care outweigh the risks
    - The resident's rights under OBRA & quality of life
    - What happens when a facility begins to remove restraints
    - Role of the family in sharing information, spending time, being open-minded and celebrating successes
    - The ever-changing needs and abilities of the elderly
- "Everyone Wins" - The Resident Care Library (Six videos, training manual & handouts)
    - The New Resident
    - Up and About: Minimizing the Risk of Fall Injuries
    - Working with Residents Who Wander
    - Getting Hit, Grabbed, and Threatened: What It Means, What To Do
    - Staying Restraint Free Evenings, Nights and Weekends
    - Now That the Restraints are Off, What Do We Do?

1. Bureau of Quality Assurance Memos are available at the DHFS web site at:

   http://www.dhfs.state.wi.us/rl_DSL/Publications/BQAnodMems.htm

   Number 98-003 - Dated April 21, 1998 - Answers questions about restraints and restraint reduction and also describes the accurate way to define, count, document and report on residents who are restrained in the nursing home and the importance of providing for the safety of these residents.

   Number 99-051 - Dated September 3, 1999 – Gives data on numbers of restrained residents based on the questionnaire distributed to all Wisconsin Nursing Homes in 1998.

2. Call the Bureau of Quality Assurance at (608) 267-1446 to obtain current federal and state hospital and nursing home regulations. Within the "Guidance to Surveyors" section, the definition of a restraint is clarified and probes for evaluating restraints are listed.

3. "Avoiding Physical Restraints, What All Nursing Home Residents and Families Need To Know" (PSL-3113, May 1998) is a Bureau of Quality Assurance pamphlet designed to assist nursing home staff in the education of families of nursing home residents. Copies of this brochure may be obtained by writing to:

   Division of Supportive Living
   Bureau of Quality Assurance
   P.O. Box 2969
   Madison, WI 53701-2969

4. The federal Health Care Financing Administration (HCFA) has a web site on the Internet that provides a newsletter with up-to-date information on restraint reduction at:

   http://www.hcfa.gov/pubforms/rrnews.htm

5. "Safety without restraints" is an excellent booklet produced by the Minnesota Department of Health and funded with Civil Money Penalty funds. The bibliography on the last page of this booklet lists several excellent resources with phone numbers to contact. This booklet is helpful for family education and can be obtained from:

   Minnesota Department of Health
   Facility & Provider Compliance Division
   85 East Seventh Place, Suite 300
   St. Paul, MN 55101
   Phone: (651) 215-8700 (800) 627-3529 Fax: (651) 215-8710
   Website: www.health.state.mn.us/divs/fpc/safety.htm

6. The Wellspring Program has helpful modules dealing with multiple resident care issues:

   - Physical Assessment
   - Skin Care
   - Falls
   - Nutrition
   - Elimination/Continence
   - Behavior Management

   The Wellspring Program
   PO Box 620556
   Middleton, WI 53562-0556
   Wellspring@prodigy.net

The Wisconsin Alzheimer's Association Chapter Network has many resources available to you at multiple offices throughout the state. The Association can also be reached at its Web page:

http://www.alz.org

7. Resources from the American Medical Directors Association (AMDA) are available on their Web site:

   - Altered Mental States
   - Chronic Pain in the Long Term Care Setting
   - Dementia
   - Depression
   - Falls and Fall Risks
   - Guideline Implementation
   - Heart Failure
   - Osteoporosis
   - Pharmacotherapy Companion to Depression
   - Pressure Ulcers
   - Pressure Ulcer Therapy Companion
   - Urinary Incontinence

   Internet address: http://www.amda.com -- Select Information, then click on Clinical Practice Guidelines. For the Wisconsin Association of Medical Directors Newsletter and other information, select State Chapters and then click on Wisconsin.

8. The Wisconsin Geriatric Education Center provides "Curriculum Modules for Training Acute Care Health Professionals Serving Dementia Patients." These guidelines are available for a nominal fee. Information on how to purchase them can be obtained from:

   Wisconsin Geriatric Education Center
   Marquette University
   P.O. Box 1881
   Milwaukee, WI 53201-1881

   Phone: (414) 228-3712
   Fax: (414) 288-1973
   Internet address: http://www.mu.edu/wgec

9. "Avoiding Physical Restraint Use: New Standards in Care" is a guide for residents, families, and friends by the National Citizens Coalition for Nursing Home Reform (NCCNHR). This organization also has another booklet available, "Avoiding the Use of Chemical Restraints" for nursing home residents. For information on both booklets:

   Address:
   Director, Information Clearinghouse
   1424 16th Street, NW, Suite 202
   Washington, DC 20036-2211

   Phone #: (202) 332-2275
   Fax #: (202) 332-2949
   http://www.nccnhr.org

10. The Mendota Geriatric Special Care Unit is available to provide consultation to nursing homes regarding complex residents. Contact the unit at (608) 243-2623 for further information.

12. "Managing Behavioral Symptoms in Nursing Home Residents: A Manual for Nursing Home Staff" is an excellent resource by Vanderbilt University that was revised in 1995 from the original 1990 version. Vanderbilt University usually grants reprint permission.

    The manual was prepared for the program of
    Continuing Education for Nursing Homes in Tennessee
    Department of Preventive Medicine
    Vanderbilt University School of Medicine,
    Nashville, TN 37232 Phone: (615) 322-5000

13. Quality Care in the Nursing Home, by John N. Morris and others, provides an excellent chapter (#31) on Restraint Reduction. Sarah Greene Burger, Executive Director of the National Citizens Coalition for Nursing Home Reform (NCCNHR), wrote part of the chapter. This book provides excellent information on other quality of life and quality of care issues in nursing homes and is an excellent reference book for staff. (ISBN #: 08151-4222-6)

14. A Life Worth Living, by Dr.William H. Thomas, M..D., emphasizes creative ways to provide for a quality life in nursing homes. This book describes what is generally referred to as "The Eden Alternative." (ISBN: 0-9641089-6-8) Additional information is available on their web site at
    http://www.edenmidwest.com

15. Preventing Falls, a book by Janice Morris, emphasizes creative ways to assess residents and how to prevent falls in the elderly. (ISBN # 0-7619-0593-6)

16. Quality Monitoring Pathway Tools information may be helpful in your facility. Especially Quality Monitoring Pathway for Domain #10, developed by the Wisconsin Association of Homes and Services for the Aging. Call (608) 255-7060 to find out about this resource.

17. Additional resources that you may want to utilize are in the guideline "Care Planning 2000."

Obstacles are what people see when they take their eyes off the goal.

BOARD ON AGING AND LONG TERM CARE

THE OMBUDSMAN PROGRAM

AND VOLUNTEER OMBUDSMAN PROGRAM+

1-800-815-0015

All calls are taken at the 800 number in the Southwestern Regional Office and are referred to the appropriate regional Ombudsman staff.

Southwestern Regional Office

214 North Hamilton Street

Madison, WI 53703-2118

Fax: (608) 261-6570

George Potaracke, Executive Director

Claudia Stine, Ombudsman Supervisor

Regional Offices

Central Office

5424 U.S. Hwy 10 East, Suite F

Stevens Point, WI 54481-8560

Southeastern Office

819 North 6th Street, Room 520

Milwaukee, WI 53203-1664

Northeastern Office

812 South Fisk Street, 2nd Floor

Green Bay, WI 54304-2269

Northwestern Office

4330 Golf Terrace #211

Eau Claire, WI 54701-3823

Northcentral Office

1853 North Stevens Street

Rhinelander, WI 54501-2129

APPENDIX B

Overheads & Handouts

Providing A Quality Life While Avoiding Restraints

EXAMPLES OF RISKS AND SIDE EFFECTS OF RESTRAINT USE (not all-inclusive)

Psychological/Emotional Effects

- **Increased** agitation, hostility and aggression
- Feelings of humiliation, loss of dignity
- Diminished quality of life, increased stress
- Increased confusion, fear
- Depression, withdrawal, isolation, desolation
- Loss of hope & internal motivation
- Anger, frustration, demoralization
- Learned dependence
- Diminished staff opinion of the resident

Physical Effects

- Pressure ulcers, skin irritation, skin tears
- Bone loss from decreased weight-bearing activity
- Stiffness and muscle atrophy from lack of use
- Increased risk of respiratory infection
- Reduced functional capacity, decreased ambulation
- Increased risk of contractures
- Decreased mobility
- Deconditioning

MORE EXAMPLES OF RISKS AND SIDE EFFECTS OF RESTRAINT USE, (continued)

- Physical discomfort, increased pain
- Serious injuries from falls
- Increased morbidity & mortality
- Increased risk of death from struggling to get free
  (Illustrated by case examples and pictures from reference articles in the section "Side Rails.")
  - Increased stress on the heart
  - Increased risk of death due to strangulation or asphyxiation
  - Risk of burns if trying to burn the restraint off
  - Risk of injury from restraint friction on the skin
  - Nerve injuries
- Increased dependence in care needs resulting in increased cost of care
- Increased constipation, increased risk of fecal impaction
- Increased incontinence
- Increased risk of urinary tract infection due to urinary stasis
- Sleep disturbances
- Restricted circulation
- Decreased appetite

BENEFITS OF INDIVIDUALIZED CARE & FREEDOM FROM RESTRAINTS

Positive Psychological & Emotional Effects:

- Increased self-esteem and dignity
- Improved quality of life
- Increased participation in decision-making
- Less confusion, depression & withdrawal
- Decreased anger, agitation, hostility & aggression
- Increased opportunities for socialization
- Increase in hope and motivation for improvement

Positive Physical Effects:

- Fewer pressure ulcers, skin irritation & skin tears
- Less bone loss and muscle atrophy
- Decreased risk of respiratory and urinary infections
- Improved functional capacity, decreased dependence
- Less risk of death and serious injury from a fall
- Fewer incontinence episodes, lower care costs
- Less constipation, fewer impactions
- Improvements in sleep and rest patterns
- Improved circulation and appetite
- Fewer chances of an accidental, unnatural death
- Falls may increase initially, but, over-all, injuries do not usually increase

Class Discussion of Successful Case Study Results:

LEGAL DECISION-MAKING

This information provides an outline of legal decision-making facts. Further information or clarification can be obtained by calling or writing to the Bureau of Quality Assurance and asking for information, including the booklet, *Your Right to Direct Your Future Health Care*. Getting the Ombudsman involved is also helpful.

Wisconsin's Living Will

If a Wisconsin resident has initiated a Living Will document prior to his/her loss of the ability to make decisions, the facility should facilitate the carrying out of this directive by the resident's physician. The Living Will is only in effect when the person is close to death or is in a persistent vegetative state.

Wisconsin's Power of Attorney for Health Care (POAHC)

If a resident has completed and signed a Power of Attorney for Health Care document prior to his/her loss of the ability to make decisions, the facility should:

- Always facilitate the resident's participation in decision-making to the best of his/her capacity, regardless of the status of his/her agent's responsibilities
- If the resident has become incapacitated but the POAHC has not been activated, facilitate its activation by having two physicians or a physician and a psychologist evaluate the resident, then document and sign that evaluation. Document the activation of a POAHC agent if the evaluation deems the resident is incapacitated or proceed as otherwise instructed in the document.
- If the resident has become incapacitated and the POAHC is already activated, the facility should involve the agent in health care decision-making with the resident.
- If the resident is incapacitated, he or she is no longer able to legally draft a POAHC document, and the facility should facilitate the guardianship process.
- Durable Powers of attorney *that specify health care decisions* that were drafted prior to April 28, 1990, can be followed, but only according to the powers specified.
- Financial power of attorney documents are effective only in financial matters, not in health care decision-making.

Guardianship in Wisconsin

If a resident is not able to make decisions and does not have a previously signed POAHC document that can be activated, the facility should facilitate the guardianship process so that the court can determine the resident's competency. If the resident is found incompetent, the court will appoint a guardian. A resident who has a guardian still participates in decision-making to the fullest extent possible, and the facility should facilitate this. When decision-making is an issue, the Ombudsman may be brought in to mediate and facilitate a better understanding of guardianship issues. (While legal representatives, guardians, or surrogate decision-makers are able to voice their wishes and *should* be involved, they cannot dictate care that is not medically necessary to *treat* the resident's condition.)

ANSWERING TOUGH QUESTIONS -- Staff Resource

These questions and answers are to supply you with facts to help formulate answers for tough questions. There is not always a quick answer. Staff should not answer questions if they are uncertain of the facts, but they should commit to finding the right answer. Often, family members need to answer their own questions. Staff should facilitate this and avoid arguing with families. Ombudsman staff can be excellent resources for helping families who have tough questions. Reading from the recommended reading lists will help you understand the origin of these answers.

"But won't the family sue us? Who's liable if we don't restrain them?"

There is nothing that can give immunity from lawsuits. The facility is responsible for the care and safety of all residents, both those who are restrained and those who are not. Most successful lawsuits have come from improper restraint use or the lack of supervision of a resident who died in a restraint or side rail. Facilities are responsible for following rules, regulations and standards of practice, including respecting the resident's right to be free of restraints. The rules also require the facility to protect residents from accidents and injury, including when they are restrained or when they are using a side rail. Regulations *and* standards of practice identify that all residents are to be comprehensively assessed and care plans developed to enable them to achieve their highest practicable quality of life and functional level. If a facility has comprehensively assessed and care planned with the resident and family and has taken all the necessary precautions to protect the resident from death or injury, the outcome of any legal action is likely to be more positive. The facility staff must ensure that they frequently check the resident and provide care that prevents accidents and injuries if the resident is restrained or unrestrained, or if the resident uses or does not use a side rail. Studies show that in the long run more than 90 percent of families favor restraint-free care, but they expect the resident to be protected from accidental death.

"But I'm the guardian, and this is what I want."

Involvement on the part of family members is a strength that needs to be used for the benefit of the resident. Staff will get the best results if they express appreciation for this involvement and work with the family on this issue. Guardians, health care agents or other legal representatives do not have the authority to demand care for the resident that is not necessary to *treat* a medical symptom. A resident or family member should not expect medical and health care staff to do something that is known to have the potential to harm the resident when other alternatives would be more beneficial and present less risk. The interdisciplinary team will need to work with the family and the resident to creatively solve the resident's issues; the Ombudsman staff can help.

"Serious injuries will increase; they will fall and hurt themselves."

Several studies have shown that, while the number of falls can increase initially when restraints are reduced, the rate of serious injuries from falls and the number of deaths from restraint use decrease with restraint reduction. Precautions need to be taken to strengthen residents and to implement measures to prevent falls.

"It will take too much time, we don't have enough staff, and it will cost too much."

Studies have shown that the cost of care does *not* increase when restraints are reduced. Some care costs decrease, such as the use of incontinence products. It takes less staff time to care for persons whose independence is maintained and this reduces costs. During a two year study in 16 nursing

homes, the staff ratio at all of the facilities stayed the same while the rate of restraint usage declined from 40.55 percent to 4.05 percent. During the pilot testing of the guideline in one Wisconsin nursing home, the percentage of restrained residents went from 32 percent to less than 2 percent.

"A side rail will prevent injuries."

Side rails are not benign safety devices that prevent injury. This is particularly true for residents with cognitive impairments or those who have uncontrolled movements. They can actually be a safety hazard, especially if the resident climbs over the rail and falls from a greater height, or becomes wedged between the mattress and the rail trying to leave the bed. This is true of both full, ¾ or ½ side rails. Lowering beds, perhaps combined with padding on the floor, along with individualized supervision for toileting and comfort needs are the way to prevent falls from bed. Most residents do not roll or fall out of bed like a toddler; they fall ***trying to get out of bed because of an unmet need.***

"Why does the state say there can be no restraints or side rails?"

The federal and state rules identify that the resident has a right to be free of restraints unless restraints are ***needed to treat a medical symptom.*** Under limited circumstances they are permitted when they provide a ***benefit*** to the resident's medical symptom that outweighs the risks, but the facility must then ensure that the resident is protected from injury or death.

"Can a competent resident request a side rail?"

Requests for side rails generally come from a perception, based on experience in hospitals and nursing homes, that they are a method of keeping someone from falling out of bed. A resident's right to participate in the care planning process and to refuse treatment, including the right of the resident to accept or refuse side rails, cannot be unilaterally denied. Facility staff should:

- Assess the resident and the request. Determine *why* the resident is requesting the restraint or side rail.
- Describe to the resident other care measures that may be safer and more appropriate. Help the resident understand how these alternatives may help him or her to feel more secure. (Lowering the bed, placing pillows on the open side of the bed, getting a different type of bed, checking the resident more frequently, especially for night-time toileting needs, etc.) Work with the resident to eliminate the risks and fear of falling.
- Explain the risks involved with the resident, stressing that side rails are not benign safety devices, and that their use may pose a *more significant risk* to the resident than *not using them.* Frequently, facilities want the resident to sign a consent form. You may want to consult your attorney, as a consent *form* is not specified in the state or federal requirements, however informed consent for any medical treatment is required.
- If the competent resident insists upon a restraint or a side rail, makes an informed decision and may even sign a consent, the physician must still make a determination that such an intervention is needed to treat a medical symptom and provide a medical order. A person cannot expect to receive an appendectomy upon request if there is no medical reason to do such an operation. Because restraints and side rails have become part of the health care culture, residents, families and physicians need objective education and support in order to overcome outdated perceptions about their use.

Questions Physicians And Staff Should Ask When a Restraint Order is Requested

Facility staff need to comprehensively assess the resident and ask themselves these kinds of questions ***before*** calling the physician. This is not prescriptive; not every question is appropriate for all residents:

1. What is the assessment of the resident in comparison to the resident's baseline?
   - Has there been a change in the medical condition, the medical symptom or the behavior of the resident?
   - Has this change been abrupt?
   - If gradual, how long have you noticed/monitored this change/issue?
   - Any medication side effects associated with the resident's symptoms?
   - Any recent medication changes that are associated with the resident's symptoms?
   - What? When? Why? (Keep asking "Why?" until you solve the problem.)
   - Any change in cognitive status?
   - Any change in functional ability?
   - Signs of infection or other acute illnesses? (Fever, delirium or more subtle symptoms?)
   - What circumstances are related to the resident's symptoms? (Pain? Hunger? Toileting needs? Environmental factors? Boredom? Need to move around? Dehydration? Loneliness? Recent relocation?) Any other "triggers'' that precede the behavior?

2. What options/interventions have been tried; how often, how recently; what resulted?
   - Environmental changes?
   - Elimination of triggering circumstances?
   - Diversional activities?
   - Increased supervision?
   - Restorative/strengthening program, assistance with ambulating?

3. What is the resident's opinion about the possible use of a restraint?
   (While legal representatives, guardians, or surrogate decision-makers are able to voice their wishes and *should* be involved, they cannot dictate care that is not necessary to *treat* the resident's medical symptom.)
   - Is the resident's family involved?
   - Is there a guardian? Is there an activated POAHC agent?
   - Does the POAHC need activation? I.e., has the resident become incapacitated?
   - Is Ombudsman involvement occurring or indicated?

4. Has the interdisciplinary team evaluated this resident?
   - If the resident has not yet been evaluated, when can the team evaluate the resident and consult the physician about the findings?
   - If a restraint order is **not** given, how will the resident's medical symptoms/condition be handled?
   - If a restraint is used, what will be the plan for getting rid of it?

5. What type of restraint is requested?
   - What medical symptom is it for and how does this *treat* the medical symptom?
   - How will this benefit the resident? Is it the least restrictive option?
   - During what time of day is it needed or for which specific circumstances or hours is it needed?
   - How long will it be needed? When will it be reduced and how?
   - What risks of injury will be present if it is used?
   - What will the facility do to minimize these risks?
   - How often will this resident need to be checked to prevent accidents while this restraint is used?

APPENDIX B

Pre-Training and Post-Training Questionnaires

PRE-TRAINING AND POST-TRAINING QUESTIONNAIRE (BASIC)

The questions below are to give you an idea of what will be discussed in this training. The instructor may have you fill this out or will review it with you verbally and discuss it. There will also be ample opportunities to discuss these questions during and after the training.

1. The state and federal governments do not allow the use of restraints in nursing homes.

   TRUE FALSE

2. Use of restraints can result in:
   (Circle all that apply)

   a. increased urinary incontinence
   b. increased skin breakdown and pressure ulcers
   c. increased weakness
   d. loss of independence
   e. decreased mental acuity
   f. increased feelings of isolation

3. Who is primarily involved with the decision-making about restraints?

   a. the physician
   b. the family
   c. the Director of Nursing
   d. the guardian
   e. the power of attorney for healthcare agent (activated)
   f. the power of attorney for healthcare agent (not activated)
   g. the interdisciplinary team, which includes the person, the physician, the family or legal representative and the staff
   h. the person

4. Side rails are:

   a. always a restraint
   b. never a restraint
   c. a restraint if they are full length
   d. not a restraint if they are 1/4, 1/2, or 3/4 length
   e. a restraint if they restrict resident movement and the resident cannot easily remove them or safely and easily exit out the side of the bed
   f. benign safety devices that do not cause any harm

5. In reviewing whether or not a person should continue using restraints, which of the following should be considered: (circle all that apply)

   a. the input from nurse aides, family and other bedside care personnel
   b. what the person's routine needs are (for example, comfort, ADLs, toileting)
   c. progress in therapy (increase in strength, improvements in ambulation, etc.)
   d. reversal of the situation that prompted the restraint (G-tube site is healed, delirium has ceased, disease progression or regression, foley is out, etc.)
   e. the person has always been restrained
   f. the physician has ordered the restraint

6. Of the actions listed below, which ones can contribute to the quality of life of a person and may reduce the use of restraints? (circle all that apply.)

   a. knowing what the person was like in their earlier days and using this information in the person's care
   b. knowing what things the person liked to do and supporting these interests
   c. spending time one-to-one with the person in activities meaningful to him or her
   d. providing for comfort and personal care needs
   e. anticipating the person's needs and behaviors and assisting him/her in solving the problem that she or he is trying to solve (toileting, walking, food, drink, etc.).
   f. controlling the person's behavior with sedating drugs, regardless of his/her diagnosis

7. A legal representative, such as a guardian or an activated power of attorney for health care agent, has the authority to unilaterally direct the use of restraints.

   True False

8. There have been no deaths or serious injuries from restraints in Wisconsin.

   True False

KEY TO PRE- TRAINING & POST- TRAINING QUESTIONNAIRE, BASIC

(Annotated)

1. False

   (They may be allowed if they are *required to treat* a medical symptom.)

2. a,b,c,d,e,f

3. g

   (However, the legal representative cannot dictate care that is not medically necessary. See "Avoiding Restraints" pamphlet.)

4. e

   (Refer to the federal definition of a restraint at F221 and the "Avoiding Restraints" pamphlet.)

5. a,b,c,d

   (e and f are *not* correct because each resident must be individually evaluated for restraint use by the team, it is not a unilateral decision.)

6. a,b,c,d,e

   (Sedating drugs are not appropriate unless there is a medical diagnosis for which they are an appropriate medical treatment. Check the language at F 222 regarding avoiding chemical restraints.)

7. False

   (Refer to the "Avoiding Restraints" pamphlet.)

8. False

   (There are from one to three deaths per year in the state of Wisconsin from the use of side rails, and sometimes more. There is no data on serious injuries. Refer to related articles with drawings of types of injuries/falls from the use of side rails.)

PRE-TRAINING AND POST-TRAINING QUESTIONNAIRE
(COMPREHENSIVE)

The questions below are to give you an idea of what will be discussed in this training. The instructor may have you fill this out or will review it with you verbally and discuss it. There will also be ample opportunities to discuss these questions during and after the training.

1. The state and federal governments do not allow the use of restraints in nursing homes.

   TRUE FALSE

2. Use of restraints can result in:
   (Circle all that apply)

   a. increased urinary incontinence
   b. increased skin breakdown and pressure ulcers
   c. increased weakness
   d. loss of independence
   e. decreased mental acuity
   f. increased feelings of isolation

3. Who is primarily involved with the decision-making about restraints?

   a. the physician
   b. the family
   c. the Director of Nursing
   d. the guardian
   e. the power of attorney for healthcare agent (activated)
   f. the power of attorney for healthcare agent (not activated)
   g. the interdisciplinary team, which includes the person, the physician, the family or legal representative and the staff.
   h. the person

4. Side rails are:

   a. always a restraint
   b. never a restraint
   c. a restraint if they are full length
   d. not a restraint if they are 1/4, 1/2, or 3/4 length
   e. a restraint if they restrict resident movement and the resident cannot easily remove them or safely and easily exit out the side of the bed
   f. benign safety devices that do not cause any harm

5. In reviewing whether or not a person should continue using restraints, which of the following should be considered: (circle all that apply)

   a. the input from nurse aides, family and other bedside care personnel
   b. what the person's routine needs are (for example, comfort, ADLs, toileting)
   c. progress in therapy (increase in strength, improvements in ambulation, etc.)
   d. reversal of the situation that prompted the restraint (G-tube site is healed, delirium has ceased, disease progression or regression, foley is out, etc.)
   e. the person has always been restrained
   f. the physician has ordered the restraint

6. Of the actions listed below, which ones can contribute to the quality of life of a person and may reduce the use of restraints? (circle all that apply.)

   a. knowing what the person was like in their earlier days and using this information in the person's care
   b. knowing what things the person liked to do and supporting these interests
   c. someone spending time one-to-one with the person in activities meaningful to him or her
   d. providing for comfort and personal care needs
   e. anticipating the person's needs and behaviors and assisting him/her in solving the problem that she or he is trying to solve. (toileting, walking, food, drink, etc.)
   f. controlling the person's behavior with sedating drugs, regardless of his/her diagnosis

7. The most important goals of training on alternatives to restraints are: (circle all that apply)

   a. finding out which alternative care interventions are best for an individual
   b. training staff in the use of chemical restraints as a means of avoiding physical restraints
   c. increasing the ability to listen to people's concerns regarding restraints
   d. helping participants grow and improve their perspectives on alternatives to restraints

8. The best way for staff and physicians to work together as a team to help avoid the use of restraints is: (choose all that apply)

   a. to always call the physician on the night shift to request restraint orders
   b. to anticipate the person's needs and meet them before he or she does something dangerous
   c. if an acute condition requiring a temporary restraint (endotracheal tube, new gastrostomy tube, etc.) is resolved, remove the restraint when there is no longer a risk of medical harm
   d. to maintain the person's dignity, and their activity and mobility level when hospitalized or in a nursing home
   e. to list all the restraints available on the order sheet so the physician can select them

9. In order for the physician and the interdisciplinary team to do discharge planning: (circle all that are correct.)

    a. Decrease the use of temporary restraints as soon as medical symptom permits
    b. Maintain the person's functional ability, including his/her decision-making ability
    c. Get family involved in preparing the person for discharge, including rehabilitation to return to the previous functional level
    d. Give information to the provider who is going to receive the person (hospital, nursing home, CBRF or home health agency, etc.) about interventions that helped prevent any behaviors or issues that put the person at risk of harm to self or others.

10. The use of restraints in a nursing home is an interdisciplinary team decision that includes the resident, the physician and the interdisciplinary team.

    TRUE FALSE

11. The objective of OBRA (The Omnibus Budget Reconciliation Act, the law that updated nursing home regulations beginning in 1987) was to create restraint-free nursing homes.

    TRUE FALSE

12. The objective of OBRA was to diminish the inappropriate use of chemical and physical restraints in nursing homes.

    TRUE FALSE

13. Some of the important roles of the physician are: (choose all that are correct.)

    a. looking into hidden medical causes for the person's condition or behavior (low sodium, digitalis toxicity, infection, delirium, etc.)
    b. helping prevent deaths from restraints in hospitals and nursing homes
    c. educating consumers, families, and hospital and nursing home staff on the risks of using restraints and the benefits of avoiding restraints
    d. advocating on behalf of a patient or resident when a nurse is requesting restraint orders
    e. assisting staff in finding creative solutions to avoid restraint use
    f. keeping up-to-date and sharing new research and professional publications that will help providers avoid restraint usage.

14. According to recent research, a restrained resident is still able to fall but is more likely to be seriously injured than an unrestrained resident who falls.

    TRUE FALSE

KEY TO PRE-TRAINING & POST- TRAINING QUESTIONNAIRE, COMPREHENSIVE
(Annotated)

1. False

   (They may be allowed if they are *required to treat* a medical symptom.)

2. a,b,c,d,e,f

3. g.

   (However, the legal representative can not dictate care that is not medically necessary. See "Avoiding Restraints" pamphlet.)

4. e

   (See federal definition and "Avoiding restraints pamphlet.)

5. a,b,c,d

   (e and f are *not* correct because each resident must be individually evaluated for restraint use by the team; it is not a unilateral decision.)

6. a,b,c,d,e

   (Sedating drugs are not appropriate unless there is a medical diagnosis for which they are an appropriate medical treatment. Check the language at F 222 regarding avoiding chemical restraints.)

7. a,c,d

8. b,c,d

9. a,b,c,d

10. TRUE

    (The resident has a right to be free of restraints. When the resident has a surrogate decision-maker, he/she cannot dictate care that is not medically necessary.)

11. FALSE

12. TRUE

13. a,b,c,d,e,f

14. TRUE

APPENDIX C

Recommended Reading

Up-to-date information is available from the federal Health Care Financing Administration's Restraint Reduction Newsletter at:

http://www.hcfa.gov/pubforms/rrnews.htm

Appendix B of the guideline "Providing a Quality Life While Avoiding Restraint Usage" also provides multiple resources for trainers. The topics or audiences under which the resources are listed are not limited to only those. For instance, resources on falls or side rails may be helpful for anyone. For some family members, especially those who are professionals or experienced in health care, articles written for professionals may be appropriate. A trainer will need to assess the person's learning needs and be familiar with the content of the article to make this decision.

Every effort has been made to include primarily the latest publications. A few older resources are listed here due to the value and unchanging nature of their content, but more recent data may now be available. Additional resources are published on the World Wide Web at the HCFA web address on the divider sheet of this section. Some additional web site addresses may be helpful:

http://www.ute.kendal.org/newsletter.htm
http://sagesite.utmb.edu/coa/sso/archive/falfroc.asp

Readers/trainers are responsible for obtaining their own re-print permission for journal articles or any other copyrighted material. The guideline and these resource lists may be reproduced and shared.

Topic/Audience

FAMILIES

"Avoiding Physical Restraints. What All Nursing Home Residents and Families Need to Know," Pamphlet PSL-3113, Wisconsin Department of Health and Family Services, Division of Supportive Living, Bureau of Quality Assurance, May 1998. It is in the public domain and may be copied.

Copies may be obtained by calling any regional office of the Bureau of Quality Assurance or by writing to:

Bureau of Quality Assurance
P.O. Box 2969
Madison, WI 53701-2969

"Avoiding Physical Restraint Use: New Standards in Care, A guide for residents, families and friends," booklet produced by the National Citizens Coalition for Nursing Home Reform (NCCNHR), copyright 1993.

Copies may be obtained by contacting the Coalition at:

National Citizens Coalition for Nursing Home Reform
1424 16th Street N.W., Suite 202
Washington, D.C. 20036-2211
(202) 332-2275
http://www.nccnhr.org

"Avoiding Drugs Used as Chemical Restraints: New Standards in Care," a booklet addressing avoiding unnecessary drugs is available from the same organization, NCCNHR, at the above address and phone numbers.

"A Family Guide to Restraint-Free Care," video for families from the video series, "Everyone Wins! Quality Care Without Restraints." It is the only video from the series that is available separately.

Available from:

The Independent Production Fund
45 West 45th Street
New York, NY 10036
1-800-727-2470
E-mail: ipt45@aol.com

"Safety Without Restraints," an illustrated booklet published by the Minnesota Department of Health.

For additional copies, call (651) 215-8700 or visit the Website at:
www.health.state.mn.us/divs/fpc/safety.htm

Portions of the booklet are available in alternative formats upon request. For information please contact:

Minnesota Department of Health, Facility & Provider Compliance Division at (608) 215-8700 or 1-800-627-3529.

FALLS

Capezuti, E., Evans, L., Staumpf, N., and Maislin, G., "Physical Restraint Use and Falls in Nursing Home Residents," *Journal of the American Geriatrics Society,* June, 1996.

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Daltroy, L., Phillips, C., Eaton, H., Larson, M., Partridge, A., Logigian, A., and Liang, M., "Objectively Measuring Physical Ability in Elderly Persons: The Physical Capacity Evaluation," *American Journal of Public Health*, April, 1995.

Lipsitz, Lewis, "An 85-Year Old Woman with a History of Falls: Clinical Crossroads," *Journal of the American Medical Association*, July 3, 1996.

Meddaugh, Dorothy, Friendenberg, D., Knisley, R., "Special Socks for Special People: Falls in Special Care Units," *Geriatric Nursing*, January/February 1996.

Morse, Janice M., Preventing Patient Falls (book) SAGE Publications, ISBN: 0-7619-0593-6.

Pasqua, Sandy, "Fall Programs That Work," *Contemporary Long Term Care*, April 1996.

Province, M., et. al., "The Effects of Exercise on Falls in Elderly Patients," *Journal of the American Medical Association*, May 3, 1995.

Ray, Wayne A., et. al., "A Randomized Trial of a Consultation Service to Reduce Falls in Nursing Homes," *Journal of the American Medical Association*, August 20, 1997.

Thapa, P., P. Gordon, R. Fought, Ray W., "Psychotropic Drugs and Risk of Recurrent Falls in Ambulatory Nursing Home Residents," *American Journal of Epidemiology*, Vol. 142, No. 2, 1995.

Tideiksaar, Rhein, "Preventing Falls: How to Identify Risk Factors, Reduce Complications," *Geriatrics*, February, 1996.

Tinetti, Mary E., W. L. Liu, E. Claus, "Predictors and Prognosis of Inability to Get Up After Falls Among Elderly Persons," *Journal of the American Medical Association*, January 6, 1993.

Tinetti, Mary E., "Prevention of Falls and Fall Injuries in Elderly Persons: A Research Agenda," *Preventative Medicine*, 23, 756-762, 1994.

Tinetti, Mary E.,. Inouye, S., Gill T., Doucette, J., "Shared Risk Factors for Falls, Incontinence, and Functional Dependence," *Journal of the American Medical Association*, May 3, 1995.

SIDE RAILS

Feinsod, Fred, Moore, M., Levenson, S., "Eliminating Full-length Bed Side Rails from Long-Term Care Facilities," Nursing Home Medicine, *The Annals of Long-Term Care*, 1997.

Miles, Steven and Irvine, Patrick, "Deaths Caused by Physical Restraints," *The Gerontologist*, Vol. 32, No. 6, 1992.

Miles, S., "Restraints and Sudden Death," Letter to the Editor, *Journal of the American Geriatrics Society*, 41 (9), 1993.

Miles, Steven, "A Case of Death by Physical Restraint: New Lessons from a Photograph," *Journal of the American Geriatrics Society*, 44: 291-292, 1996.

Miles, Steven and Parker, Kara, "Pictures of Fatal Bedrail Entrapment," Letters to the Editor, *American Family Physician*, Vol. 58, No. 8, November 15, 1998.

Parker, Kara and Miles, Steven, "Deaths Caused by Bedrails," *Journal of the American Geriatrics Society*, Vol. 45, No. 7, July 1997.

HOSPITAL STAFF

Many resources geared toward physicians and nursing home staff are also helpful for hospital staff, especially regarding falls and restraint deaths from side rails. The articles listed below are of particular interest to hospital staff members.

"Strategies to Reduce Use of Restraints, Special Report - Restraint and Seclusion Standards," Joint Commission *Perspectives*, November-December 1997, pages 18-24.

Bryant, H. and Fernald, L., "Nursing Knowledge and Use of Restraint Alternatives: Acute and Chronic Care," *Geriatric Nursing*, 18, 1997.

Clifford, Timothy, M.D., Medical Director, Maine Medicaid Program, "Why Are Hospitals Dangerous for Nursing Home Residents?," published in "Case Mix Update, A Newsletter of the Maine Case Mix Payment and Quality Assurance Project," May 1997.

Greenberg, R., "OBRA's Challenge to Physical Therapy: Find Alternatives to Physical Restraints," PT Bulletin, April 26, 1996, p. 11.

Mion, L. C., Minnick A. and Palmer, R., "Physical Restraint Use in the Hospital Setting: Unresolved Issues and Directions for Research," *The Milbank Quarterly*, 74 (3), 1996.

Robinson, B.E., "Death by Destruction of Will: Lest We Forget," *Archives of Internal Medicine*, Nov. 13, 1995.

Strumpf, Neville E., RN, FAAN, and Schwartz, Doris, "Achieving Restraint-Free Care in Hospital Settings," Gerontological Nursing School of Nursing, University of Pennsylvania, published in "Untie the Elderly," Newsletter, December, 1997.

Winslow, Elizabeth H., RN, FAAN, Presbyterian Hospital, Dallas, Texas, "Do Restraints Really Protect Intubated Patients?," *American Journal of Nursing*, June, 1996.

RESOURCE ORGANIZATION:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

PHYSICIANS

Many of the resources listed here are appropriate for hospital and nursing home staff, as well as physicians. The sections on falls and side rails are also of particular interest to physicians and professional staff.

Castle, Nicholas, and Fogel, Barry, "Characteristics of Nursing Homes That Are Restraint Free," *The Gerontologist*, Vol. 38, No. 2, 1998.

Dunbar, Joan, Neufeld, R., White, H. and Libow, L., "Retrain, Don't Restrain: The Educational Intervention of the National Nursing Home Restraint Removal Project," *The Gerontologist*, Vol. 36, No. 4, 1996.

Frengley, J.D. "The Use of Physical Restraints and the Absence of Kindness," *Journal of the American Geriatrics Society*, 44:1125-1127, 1996.

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Kapp, Marshall, "Nursing Home Restraints and Legal Liability," *The Journal of Legal Medicine*, 1992.

Morley, John E., "Update on Nursing Home Care," *Annals of Long-Term Care*, Vol. 7, No. 1, January 1999.

Schieb, D., Protas, E., Hasson, S., "Special Feature: Implications of Physical Restraint and Restraint Reduction of Older Persons," *Topics in Geriatric Rehabilitation*, December, 1996.

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Colorado Foundation for Medical Care, "Assessment and Alternatives Help Guide, Restraint Reduction, Falls, Behavior Problems, Wandering," Phone # (303) 695-3300, ext. 3005.

Dunbar, Joan, et. al., "Taking Charge, The Role of Nursing Administrators in Removing Restraints," *Journal of Nursing Administration*, Vol. 27, No. 3, March 1997.

Ejay, F. K., Rose, M. S. and Jones, J. A., "Changes in Attitudes Toward Restraints Among Nursing Home Staff and Residents' Families Following Restraint Reduction," *The Journal of Applied Gerontology*, 15 (4), 1996.

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Fleming, Kevin, "Changing Physician Behavior," *Topics in Geriatric Medicine and Medical Direction*, Vol. 13, Issue 4, December, 1998.

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Neufeld, R. R. and Dunbar, J. M., "Restraint Reduction: Where Are We Now?," *Nursing Home Economics*, 4 (3), 1997.

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Rader, Joanne, "A Comprehensive Staff Approach to Problem Wandering," *The Gerontologist*, Vol. 27, No. 6, 1987.

Rader, Joanne, J. Doan and Sr. M. Schwab, "How to Decrease Wandering, a Form of Agenda Behavior," *Geriatric Nursing*, July/August, 1985.

Strumpf, Neville and Evans, Lois, "The Ethical Problems of Prolonged Physical Restraint," *Journal of Gerontological Nursing*, Vol. 17, No. 2, 1991.

Werner, P., Koroknay, Braun and Cohen-Mansfield, "Individualized Care Alternatives Used in the Process of Removing Physical Restraints in the Nursing Home," *Journal of the American Geriatrics Society*, 42 (3), 1994.